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An Address.¹

By S. F. McDONALD, M.D. (Melbourne), M.R.C.P. (London),
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British Medical Association.*

It is your retiring President's duty each year to deliver an address, composed as it may be of platitudes, of a review of the year's work or perhaps a study of medico-political matters of importance.

I confess that medico-political matters have been my daily meat and drink for the past two years, and tonight I hope to escape them for at least a little while.

There are indeed many matters of importance over which we have toiled during the past year. For the details I refer you to the annual report, which I hope you will do us the honour of reading, and we hope the especial honour of criticizing.

In the work done in these matters I take this opportunity of thanking the members of the Council

of the Branch. We have been a very happy family and any successes we may have achieved have been due to the steady team work of various sub-committees and the Council itself.

It is invidious to speak of individuals, but four above all stand out: Dr. Clarke, our Secretary; Dr. Meyers, our representative before the Hospital Commission, whose self-sacrifice and industry you have decided to trespass upon still further in the honour you have done him by making him President Elect; Dr. Alex Murphy, Chairman of Committees; and Dr. Markwell, Assistant Secretary.

Today is for me a notable anniversary. Twenty-one years ago today my University conferred upon me a degree in virtue of which I might be registered in various States of the Commonwealth to practise medicine and surgery.

I therefore intend to look back very briefly over those twenty-one years, to consider how medicine has changed and to show how that change has affected one of the greatest problems with which the medical profession is faced—the problem of quackery.

¹ Delivered at the Annual Meeting of the Queensland Branch of the British Medical Association on December 12, 1930.

Looking back, I think that the chief thing that strikes me about my entry into medicine was my extreme ignorance. Like Kipling's mounted infantryman:⁽¹⁾

I wish myself could talk to myself as I was a year ago—I could tell myself a lot of things it would help him a lot to know.

Yet it was a time, too, when medicine was changing greatly. Take two diseases only, nephritis and heart disease. When I was a student the one authority on nephritis was Rose Bradford, now Sir John Rose Bradford, President of the Royal College of Physicians. In the chaotic state of our then knowledge his articles⁽²⁾ in Clifford Allbutt's "System of Medicine" seemed the only clear exposition of clinical fact and pathological findings which we could find. Today when we are struggling with the problem of chronic nephritis, I can assure you that his articles on the small pale kidney, a clinical entity which he was the first to recognize, are well worth rereading.

There was little blood chemistry in 1909, but there was a rough form of the Mosenthal test, in the recognition of the fact that the urine in chronic nephritis was of low concentration and that polyuria was a constant feature in the disease, while the morbid anatomy and clinical features were as exactly drawn then as we find them now.

Blood pressure readings were taken constantly and the estimation of the diastolic pressure was being recognized as a valuable clinical procedure. But the great adjuncts to the study of nephritis—blood chemistry and renal efficiency tests—were still to come. Rowntree, Mosenthal, Van Slyke, MacLean and those others whose work is now a routine part of our investigation into any case of nephritis, were still unknown, and the mechanism to balance the clinical findings was undiscovered. (Rose Bradford, who as consulting physician to the Etaples area, had described the clinical aspects of trench nephritis, was largely instrumental in persuading the War Office to send out MacLean to France in 1917 to study the biochemical aspects of the disease on the spot.⁽³⁾)

Thanks to the chemists, we can now often recognize early cases of nephritis, when symptoms may be few and slight; in the intermediate stages the clinician often requires but little assistance from the biochemist. The most important sign of all in nephritis is a clinical one, but in the final stages the end may be heralded only by a change in the blood urea or blood creatinine. When the "small pale kidney" patients came into hospital, despite our lack of tests and blood chemistry, we knew that they were doomed. As a student one of my most vivid memories is of Dr. J. F. Mackeddle holding out two shrivelled kidneys to us and saying: "Here are the kidneys from A, whom you saw last week in the ward—complete agreement with Rose Bradford, clinical and pathological."

Just as light in nephritis seemed far off, in heart disease it seemed to us that the dawn was upon us. Mackenzie was already a force in the medical

world and if London was slow to accept him, the same could not be said of our teachers in Melbourne. Some there were who had made a pilgrimage to England and worked under him, perhaps bringing back a polygraph. Such was my own "honorary" at the Alfred Hospital, Dr. A. V. M. Anderson, at whose feet I was to learn the foundations of medicine; while of the younger men, Sewell, Turnbull and Silberberg were hard at work and the whole medical school was interested and excited.

But all were alike insisting on Mackenzie's essential teaching, that the polygraph (as I have later heard Lewis say of the electrocardiograph) was an instrument of interpretation, it was rarely an instrument of detection. The experience of the clinician, his eyes, fingers and ears trained and disciplined by experience, coupled with a store of faithful clinical memories, were the real guide to diagnosis, to prognosis and to that which is based on these—treatment. Indeed Mackenzie went so far as to insist that so simple an instrument as the sphygmomanometer was of little value, an attitude which, it may be, accounts for the fact that he apparently never realized the difference between *angina pectoris* and coronary block. In this differentiation, apart from the symptoms which alone are often enough for diagnosis, blood pressure readings play an important part.⁽⁴⁾

(Indeed it is remarkable that three very important conditions of vascular disease were described by those very "giants" for whom, according to his biographer, Mackenzie had so much contempt.⁽⁵⁾ I refer to coronary blockage by Levine, chronic ulcerative endocarditis by Horder and essential hypertension or, as he called it, hyperpiesia by Allbutt.)

But in both diseases, great though the assistance of the laboratory instruments has been, it is to the physician behind them that the patient turns.

The patient is not interested in blood urea nor in inverted *T* waves. He wants to know: (i) What have I got? (ii) Can I be cured? (iii) Can you cure me? If these replies are unsatisfactory, he intends to go elsewhere. Too often the patient's point of view is forgotten, and the result is a failure of medicine.

We are all apt to forget the personal side of our patients and the most important part of this personal aspect is his relation to his physician. This attitude of trust and dependency is a very complicated one; it is not merely a matter of professional skill and knowledge, but a matter to a great degree of personality. The complete explanation is to be found in the work of Freud, but to give you his views on "transference," as he calls it and as it is generally known in psychological studies, would be out of place here. We have all seen physicians and surgeons whose professional attainments we know to be little more than mediocre, achieving an immense financial success; while others, professionally far more gifted, struggle in the ranks of the half successful. Do not think that I regard this as a reproach; I do not. This gift of estab-

lishing a transference is as vital a part of a physician's mental equipment as the skill in recognizing a cardiac murmur; it is an essential in treatment when probably three-quarters of our patients need psychological rather than material therapeutics. It is at its greatest value in all forms of chronic disease. It is an aspect of medicine I shall turn to later in discussing the methods of the quack.

But with the establishment of modern "scientific" medicine there is a very great danger of our losing this personal factor. With all due respect to those who believe that the future of medicine (and of surgery, too) lies in team work, I venture to suggest that the interests of the average patient are best served by the care of one physician who is, in the very real lay phrase, "in charge of the case."

Henry Ford, who brought team work in car building to an entirely new height, has built a hospital where medical team work is carried out to a wonderful degree and the final diagnosis is made by a consultation between "seven physicians" (in the United States of America, of course, "physician" includes surgeon).⁽⁵⁾ What is the attitude to this of the ordinary patient with his trust in "my doctor"? (Incidentally I may say that in the present and recent lodge controversies one of the objects of the Association has been to maintain the patient's personal interest in his doctor under a system of open choice; the buying and selling of patients and their mass transfer by lodge secretaries is a thing of the past.) Above all, what is the attitude of that very numerous and increasing class of patients of whom the largest section consists of those so faithfully described by Robert Hutchison as suffering from "the chronic abdomen"?

They have been studied at further great length by Bedingfield and here let me give you two quotations, the first from Robert Hutchison, describing the manufacture by "team methods" of the unhappy "chronic abdomen." He says ("Lectures on Dyspepsia"⁽⁶⁾):

Meanwhile, and between the more dramatic entries and exits of the surgeon, the physician has not been idle. The patient has been thoroughly "investigated"—possibly, if she can afford it, at a "team work" clinic; she has certainly been provided with an X ray picture book of her entire alimentary canal; her teeth have been extracted and her tonsils excised; her motions have been analysed by a biochemist and her mind by a psychoanalyst; she has had several rest cures; she has been given prolonged courses of vaccines, of intramuscular tonic injections, of intestinal antiseptics, and of endocrines; she has been fed on sour milk or minced beef or raw vegetables; she has experienced various forms of massage, has been subjected to the latest kinds of electrical current, and has had her colon repeatedly washed out at Plombières or Harrogate.

In a word, she has run the whole gamut of "modern" therapy, has submitted to every "stunt" and conformed to every fad, but is none the better. And just as she can only escape the attentions of the surgeon when, as Sir Clifford Allbutt said of the gynaecologist, he is "grouse-shooting or salmon-catching or leading the fashion in the Upper Engadine," so she is only at peace from the physician when the latter is recruiting his exhausted energies by a short holiday in a boarding house at one of the less expensive seaside resorts.

Bedingfield, writing of his own initiation into medicine, says:⁽⁸⁾

Graduating in 1911, I saw ahead of me nothing but a vista of laboratory findings which under my marvellous clinical acumen would, like a jig-saw puzzle, reassemble themselves until symptoms, physical signs and morbid anatomy became like the Trinity, three in one and one in three. But alas! Three months in medical O.P.'s and the demon of doubt had already raised its head amidst the "Rep. Mists."

Further, he says:⁽⁷⁾

The first step in the treatment of the chronic intestinal invalid is to secure the confidence of the patient by a thorough, but not excessive, general medical examination. Hutchison is right in stressing the harm done to these patients by the modern "clinical team" method of investigation. When the clinical findings turn out to be negative, the greatest care, tact and sympathy are required in explaining to the patient how genuine distress and real ill health may exist in the absence of any definite disease.

The full development of this medical "mass production" method is best studied at length in Morris Fishbein's "Doctors and Specialists," which I implore you all to buy and keep, and read, mark, learn and inwardly digest. Do not lend it; make the other man buy it and keep it. Turning over the pages, do not think like the Pharisee: "Thank God I am not as these Americans," but rather: "Am I without sin that I can cast a stone?"

Now, Sir, were it merely the effect on ourselves, matters would be bad enough; but I believe that much of the modern loss of the individual touch in medicine is having an even more sinister effect.

In the United States where medicine is organized as nowhere else, so that a patient put into a clinic at one end comes out the other, completely fitted with new parts, "ducoed" and all bearings greased; where the work of nurses in a ward is studied by efficiency experts, so that the introduction of a bed pan with the left hand is found to save 0.25 second and the holding of it 0.34 metre above the sink saves 0.94 second, it is in this very country that there is a higher proportion of quack and unqualified practice than elsewhere in the world.

Dr. Fishbein describes a tonsillectomy under the Ford system ("Doctors and Specialists," page 29):

The robot having been told by factory doctor 45 that his tonsils should come out, goes to Tonsil Station K by appointment, Tuesday morning at seven a.m. On arrival he is at once ticketed as R-Sct. 3765 (Robot Subclass Tonsils 3765). As he enters, his clothing is automatically removed; he pauses under a shower of warm water, is dried by a blast of hot air, he is encased in a sheet, and moves on under his own power to meet a technician, CS 37, the cocaine smearer, who smears the throat and surroundings with cocaine to dull the reflexes. Then he goes to PP 42, the procaine pusher, who shoots in procaine at preferred points to block the nerves of pain. Now he advances still on his own power to a chair moving on a belt where he is seated and carried to RTS 21, a right-handed man, the right tonsil snatcher, who snares forth the right amygdaloid organ, and then still in the chair, by the pulling of a lever, to LTS 21, a left-handed man, who snares the sinistral amygdaloid encumbrance. Another jerk of the lever removes him to the tender ministrations of MR 46, the mucus remover, HI 28, the hæmorrhage inspector, BVT 41, the blood vessel tier, and CA 25, the chair adjuster. Now he finds himself in a horizontal position being gently eased into Ward 8, Bed 12, where he is visited at periodic intervals by IBC 12, the

ice-bag changer, N 5, the nurse who holds his hand, takes his temperature and keeps the record, D 9, the dietitian who picks and supplies his food, and the maiden who watches out for his physiologic necessities, a specialist with post-graduate training in Chic Sales' school. On Wednesday the patient rises on his own power and passes out through door 21, through another shower, through another blast of hot air; he receives his clothes which have been renovated and pressed, sees cashier 23 who charges him just what he had in his clothes when he entered the door, and departs back to a life of turning bolt 91 on axle 92 until some other part of his anatomy succumbs to the wear and tear of human existence.

Heaven grant, friends, that the picture is false, but already there are institutions for the treatment of venereal disease by modern specialists where the technique departs but little from this efficiency. The doctor does not know his patients, the patients do not know their doctors, and as far as any of them personally are concerned only the cashier seems to give a damn. This, colleagues, is a system. One pauses in admiration.

But daily thousands of patients are turning away from such delights to put themselves in the hands of Christian scientists, chiropractors, osteopaths, Abrams box experts, food cranks, electro-curers, nature-curers—all sorts of sellers of stuff in bottles (*vide* O. Henry: "The Gentle Grafters") and every possible kind of crank and knave ready to prey upon a credulous public.

Unfortunately, too, in this country the quack flourishes; and I would ask you to consider for a few minutes the reason for this prosperity.

Whenever medical men are gathered together, sooner or later the talk turns on quacks and quackery, the damage done, the victimization of the unsuspecting and too trusting victims, the ignorance of both quack and patient, but the final verdict is that the quack is a very flourishing individual. Recently a leading "herbalist" admitted an income of £12,000 a year for income tax purposes, a princely income even for a great surgeon with a lavish operating *clientèle*, a sum well beyond the possibility of a physician or general practitioner. What are the factors which make for such a success? Why should the general public (and a public comprising all ranks) be willing to pay out these amounts for advice and treatment which by any scientific standard appear perfectly valueless?

There are, I believe, two factors—the first is in the quacks and the second in the medical practitioner—reacting on the psychology of the public.

Let us take the factor of the quack first. It is, I believe, mystery. One has only to move a very little time among the citizens of this State to discover how superstition and mystery are alike worshipped as the one true God—charms, lucky days, unlucky days, table turning, fortune telling, all make an immense appeal to the average citizen or his wife. Similarly, in matters medical it is far more exciting and impressive to be told that "you are suffering from falling of the liver; what you want is so forth and so on, and this draught and that draught and electric massage and this, that and the other," than to be told "too much work and worry, too much alcohol, too many late hours and not enough exercise." While the physician's prescription seems a poor thing alongside the

elaborate *régime* and nauseating compounds of the quack, European or Oriental.

A diagnosis made by applying one hand to the pulse and another to the temple is much more impressive (though anatomically more absurd) than one obtained after an hour's detailed examination with possibly an X ray examination or blood test, and at the end a mere diagnosis of "nerves"—an insulting diagnosis, too, to a patient who is firmly convinced that she (or he) is seriously ill.

Every now and then, too, marvellous cures are reported from the herbalist in cases in which the medical man or men failed completely. Now the experienced physician is only too ready to admit that a patient undergoing some completely unorthodox treatment may improve and become cured, but he will also be slow to admit that it was the treatment which caused the cure. He has constantly before his mind the dictum of old Ambroise Paré, the great surgeon of the sixteenth century: "I dressed the wound; God cured it." "But," some members of the public will say, "undoubtedly the herbalist and Chinese have some cures which are valuable and which they keep secret, and of which doctors know nothing." It may be so. I shall quote an instance shortly, but to the real physician such a state of affairs aggravates, not mitigates, their offence. For from our student days we were taught that we must never use secret remedies, that even should we, by much labour and sacrifice of leisure and money, discover some new cure, method or appliance, we must make it open to the world as soon as we were sure of our facts. If financial reward occurred indirectly, well, so much the better for us; should it not, so much the worse, but there must be no secrecy and no cornering. To an intensely commercial and material public like that of Brisbane which believes in getting six penn'orth for sixpence, or £5,000 for 5s. 3d., such an attitude is no doubt mad or at least quite foolishly altruistic, but there it is. I am aware that there are those who have fallen away from this high ideal; they have gained no doubt financially, but in the eyes of their colleagues they are the lowest of outcasts. To the average practitioner nothing is so surely the mark of a quack as the use of secret remedies and apparatus.

Let us consider some of the medical discoveries of the last twenty years, and especially in this aspect of secrecy.

First there comes the famous drug "Salvarsan" and its various successors, "Neosalvarsan," "Sulpharsenol" and so on. Ehrlich, the discoverer, was, I was once told by a former pupil, bound, under the terms of money lent him to carry on his research, to a great aniline company. This company was to have the exclusive rights of market and manufacture in case his discoveries turned out well. When "Salvarsan" appeared on the market, only after exhaustive tests by Ehrlich and his pupils at first, later by selected practitioners throughout the world, it was a patented substance, a monopoly of this famous chemical house. The situation pro-

duced a storm of indignation at the time, but there was not and is not any law to prevent it, and "Salvarsan" became a glorious German monopoly. It took the war to break the monopoly, and in a few months preparations as good as, or often superior to, the original German preparation were being made in England, France and America. Certainly the firms so manufacturing were limited, but this was a purely government action to prevent the exploitation of the public by incompetent firms whose products would either be inert or more probably dangerous. But consider here the difference between "Salvarsan" and Mr. So-and-So's patent preparation (vegetable only—no metallic poisonous substances) for the treatment of the same diseases. "Salvarsan" was the product of a great chemical laboratory controlled by some of the greatest living chemists, checked at every stage, its composition known, controlled and available for everyone to see, finally delivered to the user for exact administration to a patient suffering from a correctly diagnosed disease.

How different the brew of "herbs," the nature, composition and preparation of which are known only to the purveyor and often not to him, for too often he is completely ignorant of the final ingredients, active or inert, in his potions.

Let us take the case of insulin, a discovery which has saved hundreds of lives and restored thousands to work and happiness. It would have been quite easy for the little group of Toronto workers to have kept their method secret and only sold their preparation as a remedy for diabetes. It may be said that no one would use an unknown drug, but no one could refuse to employ such a wonderful drug as insulin. Think of the fortune this little group might have made. So far as I know, they have made nothing. Again, insulin cannot be made by all and sundry, the Toronto workers took out a patent; but under that patent every firm showing its capacity for making insulin is allowed to do so. In the British Empire this permission is granted by the Medical Research Council of Great Britain. Only institutions (in Australia the Commonwealth Serum Laboratories) which can give proof of their fitness are allowed to manufacture and market insulin. How necessary this action has been is seen in the number of quite useless and inert preparations, usually with a plausible name, immediately put on the market until their advertisements were rejected by medical journals. But there is no real secrecy about insulin.

Still more recent is the example of the use of liver feeding in pernicious anæmia. Four years ago we were almost helpless in cases of pernicious anæmia; we tinkered and puzzled and hoped; often that particular attack improved and we rejoiced that our measures were so successful; sometimes it did not improve and we used those same measures without avail. It is still too early to talk, but the liver treatment so far seems to promise if not a permanent cure, at least a method of control. Now

the active principle of the liver which does the work is a comparatively simple substance and is now available in a much concentrated state, thus obviating the consumption of half a pound of liver daily by the patient. We are saving, temporarily at least, thousands of lives and returning hundreds to apparently normal health, but I do not think that Dr. Minot and Dr. Murphy have made one penny directly from the treatment. Surely they must be men lacking entirely any business instinct. Some of our local go-getters would have taught them better ways than that.

Let us take another example which illustrates my point even more directly. Often I have been told by asthmatic patients that they have had a mixture from a Chinese herbalist that stopped their attacks at once. Now it is notorious that many asthmatic attacks are of neurotic origin, so that they start with a nervous suggestion and another nervous suggestion, for example, a drug, really quite unimportant in itself, but carrying a very heavy charge of mystery and suggestion, may suffice to end the attack. Moreover, no patient had ever been able to supply me with any of this magic herb. Others, however, were more lucky and one at least of the Chinaman's asthma herbs was found to be a plant called in China Ma Huang, in botany *Ephedra vulgaris*. The active principle has been isolated, anybody can make it, and it is sold under the name of ephedrine, a new and valuable addition to our stock of potent specific drugs. Hitherto the only drug that would do just what ephedrine does in asthma has been adrenalin, or epinephrin, the active principle extracted from part of the adrenal gland. But there is a big difference between the two with all the advantage on the side of ephedrine, for adrenalin must be given by hypodermic syringe and needle, ephedrine is taken by mouth. Now the Chinese has had his remedy all these years and he has kept it carefully to himself; it could be given only in a nauseating mixture and it was only to be obtained from the Chinese.

Western medicine has refined it, isolated it, made it available to anybody who needs it, therefore we must encourage the Chinese to compete with European methods.

Recently it has been possible to isolate the actual causative organisms of scarlet fever, to prepare an antiserum and a testing serum which would show us which of a number of children would be susceptible to the disease and which immune. Of those chiefly responsible for the success stand out Dr. Dick and his wife. Now these two probably earn at their particular work less than any ordinary factory manager in their country (the United States); they have discovered methods which would save their country millions of dollars a year, but their attempt to gain even a small relative reward by patenting certain processes has aroused a prodigious storm which, I believe, is only now subsiding.

The "magic boxes" of Abrams, afford an example of a secret remedy—the purchaser (or lessee more

correctly) is forbidden under a large penalty to open the boxes to find out their nature. Unfortunately the inventor of the system knew so little about modern radiography that he quite forgot the use of X rays and by their means the inside of Abrams's boxes became as clear as day, revealing the very simple and rather crude apparatus they contain.

But these are only odd instances of the power of mystery in quackery; there are thousands of others, ranging from sugar for alcoholism to burnt magpies for epilepsy. The importance of secrecy is very evident from the outcry which is always raised at any attempts by odd governments to have the formula published on the label.

The attitude of the medical profession may be in fact summed up in the somewhat illogical sentence: "We do not believe that the quack has any wonderful secrets; but if he has, he has no right to such secrets, nor has anyone else, but the whole community."

There is another reason for the success of the quack, a reason much less creditable to the medical profession.

If we look back over those of our patients who have placed themselves under quacks, we shall find that most of them fall into two classes, the neurotics and the incurables.

Let us take the latter first as the simpler. If we ourselves were told that we had a disease (not necessarily a fatal one) for which orthodox medicine could do nothing, would we not try anything, anything at all that held out prospects of cure? Still more so if the disease were a fatal one.

The old friend of a colleague developed an inoperable carcinoma. He was seen by some half a dozen first class surgeons who all gave the same answer. A week after the last consultation my colleague was told that the patient was having Abrams treatment. Having some knowledge of the results of such treatment, he remonstrated and the patient replied: "You all say you can do nothing for me. This man says he can. You talk about wasting money; it's going to be no good to me when I am dead and if it will keep me alive it's worth spending it all." Grim logic, but unanswerable.

But apart from fatal disease, there are many disorders which may be only moderately troublesome but for which medicines can do little, chronic bronchitis, mucous colitis, some skin diseases or abdominal adhesions, for instance, and very often the doctor does not really try. Very often he makes a diagnosis, usually a correct one, and tells the patient that there is nothing much we can do. Very often, indeed, it is done from a mistaken sense of kindness, to prevent the patient spending his money on treatment which will do him no good, and the average patient does not want to save money. (If he wants to save money he does it very easily by not paying his doctor's bills; so that's quite settled.)

He is quite willing to pay to have all sorts of things tried, X rays or vaccines or abdominal massage or the rest, and will probably brag to his (or her) friends about it afterwards. Most patients in this condition will go on trying things as long as the doctor likes to recommend them, and if that doctor won't, well he'll go to someone who will,

doctor or quack. And the quack always will, at least as long as the patient has any money. And sometimes (for *vis medicatrix nature* is a wonderful thing) the patient gets better and great is the triumph of quack and patient and great the chagrin of the doctor.

There is no doubt, too, that the mere visiting of patients with chronic and hopeless conditions is too often perfunctory and neglected; it is a heart-breaking thing to call day after day upon unfortunate people for whom we can do nothing, who are relapsing into hopeless invalidism or worse and who expect their doctor to be bright, cheering and encouraging, when he himself is too often tired, depressed and worried. It is said that doctors charge far too highly for visits to incurables for whom they really do nothing; I can think of few services so inadequately paid as a visit to a patient dying of malignant disease.

But it is above all in the neurotic that the quack scores. Now there are two ways of treating neurotic patients. One is by making them realize their own natures and their relation to their symptoms, the other by letting them cherish their symptoms and rely on the doctor.

Now the first of these methods is very difficult and tedious. It involves a long history and examination, then an attempt to sort out what is real (if, as is too often the case, organic and nervous are bound up together) from what is imaginary. Then one has to explain all this to the patient, listen to his or her protests and answer them and so on, often a good hour's work and work of a very exhausting nature. It is little to be wondered at, then, that the busy practitioner with his waiting room full of people, a sick baby, "urgent," in the next suburb, and a long time since breakfast, is apt to be short with such people, tell them bluntly to "buck up" and perhaps slam down a stock prescription with: "See how that helps you; see me again next week," with more than a hint that the whole illness is really quite imaginary.

Not so the quack; by him they are welcomed, their story is heard, hand seized, one finger placed on the pulse, another on the forehead, a few moments of intense thought (for the average quack is always a little "psychic") and then the verdict: "A dislocated liver, a twisted solar plexus, too much phlegm behind the eyes" and treatment follows. It may be by special manipulation or massage (according to the particular school of the practitioner), it may be herbs, herbs delivered even by spirit hands. And after that what could you get but a cure?

There is, too, a great advantage that the quack has over the medical man, and that is language.

We do not, I think, usually realize the immense distance that medical phraseology has moved from that employed by the people. If you do not believe me, sit down and try to explain to an intelligent layman the use of insulin in diabetes or wherein pyelitis differs from Bright's disease. The quack has none of these difficulties; his medical phrase-

ology is the popular mediæval phraseology and he uses it with great advantage.

The poor medical man in his struggle to be exact resents giving "something to cool the blood" at an anxious parent's request; he tries instead to explain something about allergy and specific protein reactions, with very little comfort to the mother of the child scratching with urticaria.

The second method of treating neurotics is, as I said, to humour them, to help and encourage them, let them think that they are ill (as indeed the neurotic is ill, though not in the ordinary sense), give them drugs and treatment which will act largely by suggestion, diet most carefully and be prepared to spend much time over them. To do this requires the winning of their confidence (no easy matter) and retaining it (usually a much simpler), an art in which the quack excels and in which the medical profession gets but little training. It is indeed a method of very great value in suitable cases, and the ordinary successful practitioner is using it to some extent every day. But it is the quack who has carried it to a real art and who thrives most by it. It is the quack who has made the nervous patient too often a burden to his family, mentally and financially; and he it is also who sometimes achieves the cure orthodox medicine had failed to produce.

Conclusion.

And what, Sir, is to be the cure for this lamentable state of things? I believe, Sir, it is in education, education of the public and education of the medical profession.

As to the education of the public, I sometimes despair after reading the drivel written on medical subjects by some of the world's most brilliant teachers and knowing the folly of their actions. (There was a general who carried a rod of vulcanite always in his pocket to cure rheumatism and got no effect unless it was in his right pocket.)

It may be, with a general increase not merely in scientific knowledge but in scientific attitude, that we shall eliminate the quack, but democratic government and a press largely swayed by the advertisement department will be heavy handicaps.

With regard to ourselves, the remedy is easier to prescribe, but still difficult to apply. There must be a constant reminder (it was a commonplace when I was a student) that we practise an art and do not drive a trade, and that our treatment of patients is as much psychical as physical.

The student should be taught that there may be quacks on the register as dangerous as those off it; and above all, too often it is opportunity makes the quack.

And finally a word to ourselves. In that never to be sufficiently repeated dedication, Stevenson said of us that "we had a generosity common to those who practice an art—never to those who drive a trade," and it is my own feeling after my term as your President that it is lack of this generosity and lack of ability to realize the other man's

interests and points of view that cause all the squabbles which come before the Council.

It is easy to condemn another man, but let us all remember the famous remark of Richard Baxter (or half a dozen other famous persons) as he watched a criminal on his way to Tyburn: "But for the grace of God, there goes Richard Baxter."

The chief aim of my year of office has been successfully to maintain our medical profession as a happy family. Of my success or failure I leave you to be my judges.

Should you, gentlemen, consider that I have achieved any measure of success, I ask you to look back and attribute that success to those good physicians and surgeons who as my honoraries and teachers so greatly influenced me at the most impressionable stage of my life. Dr. A. V. M. Anderson, Dr. J. F. Mackeddle, Sir Richard Stawell, Dr. F. V. Scholes and Dr. A. Jeffreys Wood were some of the physicians, while among the surgeons were Mr. John Cooke, Dr. Peter Bennie, Mr. J. S. Buchanan and, above all, that great surgeon whose proud boast it is that "I was a surgeon under Lord Lister, my boy," just as, no doubt, today I am inclined to let my house physicians see that my proudest memory is that I was once a house surgeon under Mr. Hamilton Russell.

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ON THE BODY AND SOUL OF A HOSPITAL.¹

By R. SCOT SKIRVING,
Sydney.

WHEN I was told that you had to endure an address from me today, I cast about for a subject suitable to the occasion. After thinking over several possible themes, I decided that, as this is essentially a family affair, a meeting indeed of the children of a mother common to us all, that the most appropriate would be the hospital itself and our duty to that professional bosom where most of us were suckled and where all of us were reared to adult life. I had in fact put together most of the notes of what I purposed to say when Dr. P. Fiaschi lent me Harvey Cushing's delightful collection of essays which he has published under the name of "*Consecratio Medici*"—one of these essays dealt

¹ Read at the first annual reunion of the Royal Prince Alfred Hospital Residents' and Ex-Residents' Association, October 7 to 11, 1930.

with just such a subject as I have chosen—but also how much better than I can present it to you today.

However, like Robert Louis Stevenson, in "Underwoods," I have partly stolen my title from a better man and have called it "The Body and Soul of a Hospital."

Cushing begins his address by saying that "Hospitals and human beings are much alike inside, for they both 'take in' and 'both evacuate'." Between these primary and terminal events there takes place within the body of the hospital the various functions of its existence, performed by those whose duty and life's work make the hospital their professional mother. On their actions, their studies and their sustained effort "to practise a sublime art not frivolously" depends the soul of the institution, whether its influence on the community and on the common stock of knowledge is to be one of honour, respect, usefulness and progress, or something very much the opposite, for even marking time in our art and craft will not, or ought not, suffice.

The body of a hospital, "the raiment," to use Cushing's happy word, may often count comparatively little, for not only within palatial structures of stone have great discoveries been made or the highest skill shown in the lessening of human suffering. I need not labour this point. No doubt a great, well equipped hospital is best, but do we not all recall instances of small institutions, with small staffs, whose energy and goodness of service may well be the admiration and despair of greater and better endowed fields of work?

The soul of a hospital, big or little, shall therefore not depend too greatly either on the vastness of its buildings, the number of its inmates or its wealth, but rather on the quality, and to a less extent *pro rata* on the quantity of its useful personal service to humanity, and this depends on those who serve it, their character, loyalty, keenness and perseverance. May I go further and say that this service does not mean that of those only who after pupillage remain through life as members of the staff, but embraces others whose path in life has led them far afield from their *Alma Mater*.

What they do of useful work may and ought to be considered as part of the common contribution of work born and put forth by all those who have been taught within the walls of this, their parent hospital.

Our hospital, indeed, is not yet an ancient refuge for the sick and hurt, hoary with years and tradition and sanctified by centuries of human suffering, endured and relieved within its time-worn walls. It is not yet an *Hôtel Dieu* or Saint Bartholomew's, to mention only two great hospitals, where many generations of men and women have devoted their lives to the relief of their fellow men and the education of the disciples of Saint Luke. Such glory and deserved reverence are still to come by the passage of years and the sustained labours of many. Yet it, too, young in years as it is compared to perhaps hundreds of European hospitals, is making a history

and tradition and as the years pass, finding a soul of its own. The index, indeed, of such spiritual and individual growth may be reckoned by the work already done, and the impulse to form such a society as we inaugurate today, with its special and individual interests, its aspirations and its declared desire to show cause for its existence by work actually done by those who turn to the Royal Prince Alfred Hospital as their *Alma Mater*.

In spite of a debased and insincere communism and its practical application in Russia, and the wicked efforts of our local Bolsheviks to spread a similar poison in Australia, we still, let us be thankful, believe *en masse* in patriotism and loyalty to our own country, the factors, indeed, which make nations great, not necessarily at the expense of others, but rather as an example to them of work, thrift, perseverance, usefulness and honour.

So, too, in a lesser sphere, in the humbler parochial patriotism of us who rejoice to be the children of the Royal Prince Alfred Hospital, it is right and proper that we should glorify her, not by "vain boastings such as the Gentiles use," but by our own work and conduct of life.

If it is, as Bacon says and I so often quote, that "a man is a debtor to his profession and as he gets his living thereby, so ought he, by ways of amends, to endeavour to be a help and an ornament thereunto," so, I say, we, educated within these walls, should try to be a credit to the means which put knowledge within our reach and seek to make the hospital a home and a shrine of light and learning.

Much excellent work has already been done by men and women taught here, but that work and learning has quite rightly been often largely dependent on the labours of others and so not directly the output and result of purely Prince Alfred experience. This, of course, must always be the case, more or less, for we are the co-heirs of all who have anywhere preceded us in the search for knowledge. I think, however, not the least of the reasons why we found this society is that one of its main functions shall be the preparation and publication of collected papers, conceived and executed, directly or indirectly, by means of personal experience and research within or through this hospital. Such bulletins of work are already usefully in vogue in various well known clinics in Britain and America.

In such a publication, as I conceive it, will be found, as I suggest, papers reflecting the actual work done by our members, who, I repeat, have directly or indirectly gained their opportunities and experience from this hospital; such papers then are really hospital contributions to medicine. Some such plan seems to many of us to be the best way of encouraging a good use of the material laid open to our study in our daily work, and may it not, too, engender a personal pride in trying to pay back the opportunities given us? Just the practical fulfilment of Bacon's advice I quoted a minute ago.

I have already said that our hospital is no ancient institution comparable in venerability with many British infirmaries, yet, when I consider its juvenility, I can honestly say, without being swayed by the false balance of affection, that it has thriven well and justified its existence in work done and service rendered. Its activities, remember, are still spanned by the duration of an average human life, even of the period of a man's working productive years, for it was indeed only opened for the reception of patients in 1883.

I suppose no one has tried to fix the epoch, in some "distant corridor of time," when, in the ascent of man, the latter could be said to possess a soul. In good truth, even now I am persuaded that a great number of persons with the semblance of humanity have not reached that point in the spiritual evolution of the primates. If I am in error in that supposition, then it is a pity that the contrary should be known, for if many such persons do really possess souls, I am afraid we must regard them of dark variety. Nor am I going in this connexion to be so meticulous as to fix a date in which a soul entered into the life of this hospital.

I think, in keeping with modern doctrine, we may say it has grown gradually, but it may be years yet before its visibility shall be fully apparent to those of our craft who live in other lands. Let us and those who follow us, strive so to make it shine.

When I turn my thoughts on those who have laboured for or within this hospital, I fear to fall into an anecdote. Yet I am minded to recall some of those who helped in its early years to make it what it has already become—a great hospital for the relief of suffering and a great clinical school for the education of medical men and nurses. I remember them all—those who rest from their labours and those who still toil.

Justly we ought to remember Alfred Roberts. He it was who mostly fashioned the "raiment" wherein a soul was to be implanted. I confess I did not always see eye to eye with him in some things; nevertheless, I held him in high esteem and regarded him as an ornament to the profession he served. He was indifferent to personal gain, but was possessed with an urgent ambition to found a hospital on modern lines. And he succeeded, for he lived to see the child of his old age growing and vigorous. He planned grandly and with the help of others, such as Edward Knox and Anderson Stuart, much of the actual structure as we see it today was in existence, even while he was still with us. His was then not a frustrate life.

Of the honorary staff several members remain most dearly in my recollection. George Fortescue, a striking figure, handsome, debonair and well knowledgeable in the then state of surgery, anxious to learn the methods of Lister, but a little inept in the automatic cult of asepsis. A good all-round man, one whose culture outside his profession was a great incentive to his juniors to like studies. A dear

man, indeed, who would have been a leader anywhere.

Then there was Alfred Shewen, a really fine physician. Were he alive today, I believe he would be in the front ranks of the most modern among you. Nor should I forget Thomas Chambers, the father of gynaecology as a specialism in Australia, quaint in speech and ways, careful and neat in operative work and a wise diagnostician.

I might talk much of others of that distant epoch whose names and ways are still fresh in my memory, a few happily still with us, who, by precept and example, within these walls have taught wisdom, confidence and craftsmanship to many generations of learners.

Nor must I silence keep
Of you, oh ministering women fair

who, with scant reward, saw the sun rise and set on their daily tasks and nightly vigils—the nurses. They, too, played a conspicuous part in making that spirit of service and usefulness of which you now see the result in ward or theatre.

Even as among the doctors, so also with the nurses, there were some inefficient, some who had mistaken their vocation.

Happily, in nursing at any rate, the initial drudgery and elementary discipline of the broom and scrubbing brush, not to say an early and indiscriminating matrimony, not seldom depleted their ranks of the unfit and occasionally of the fit as well, yet left a leaven of able, devoted, young women to whom the thanks of the staff are justly due, for without their care, capacity and loyalty, no practical success in the treatment of disease could be possible. I think with happy memory of old friends among them, dead and living, with affection and respect. Murray, Davis, Dickson, Sanders and Low—the latter still here—on watch, to mention only five great nurses.

Then there was the lay staff. Take William Epps who has conspicuously shown in his long term of service how far knowledge and industry can make the position he still holds so supremely useful to the growth and management of the institution to which he has devoted the best years of his life.

The long procession of useful lives, well spent in honourable service in all ranks, passes before me and in all grades I can happily remember many faithful servants whom it was a joy to know, who did their work, however apparently obscure and dull, with industry and care. Surely, perhaps unknown to themselves, they "made drudgery divine," for:

Who sweeps a room, as for Thy laws
Makes that, and the action fine.

Take Alexander Wilson. Will any of us, young or old, forget "Sandy"? His cheery optimism, his deft craftsmanship and his unique, unsurpassed knowledge of theatre work. I think he must, in his unobtrusive way, have been very often a pillar of strength in many fateful moments in the life of

young aspirants to operative fame. What a surgeon he could himself have been.

Then there was our old friend Peters—"Doc." Who was wiser or safer in the dispensing of dangerous drugs? Rattigan Hornes, Baker, Mrs. Curry and others, too, were part of the composite picture of the life of this great hospital as seen by the students of successive years.

It is a temptation to babble on here with trifling tales of the earlier years of the Royal Prince Alfred Hospital, a place indeed which must be endeared to many present by public duties and private affections, but I must have mercy upon you and hold my peace.

I think that the making of the soul, the personality, call it what you will, of a hospital is even as the making of one's individual character. It is just the corporate blending of various influences on the life conduct of those who worked within the walls. If they were receptive, zealous and upright, men who looked on their high calling with altruistic eyes, then their work was expressed and reflected in the good name of the hospital they served.

When the Royal Prince Alfred Hospital was opened, the older men in Sydney did not really know the practice of Listerian surgery. Some were anxious to learn, others, even as at home, were indifferent or antagonistic to the new methods.

The younger doctors brought out to New South Wales a fair knowledge of antiseptic treatment, including, of course, the spray and carbolyzed gauze dressings, but asepticism, with its meticulous, unconscious, automatic observance of certain common sense rules such as obtains now, did not prevail. Very much fewer operations were performed. Happily, the great cavities of the body were not often invaded by ungloved hands and insufficiently clean sponges and instruments.

The death rate *pro rata* for these fewer cases in the 'eighties of the last century was far higher than obtains now.

Not only did the developments of Listerism affect the preparation of patients, surgeons, instruments, ligatures, sutures and swabs (remember horrible, insufficiently cleaned sponges were used in those days over and over again), but it also influenced favourably the very building or reconditioning of the hospital in its later developments, notably in the theatres and their annexes.

I stand indeed amazed by the incredible advances which I have lived to see during the life of the hospital, in medical knowledge and surgical practice, but perhaps most of all in our use of the ancillary sciences. Think of the value of X rays, electrical treatment of all kinds, radium and its far flung possibilities, and biochemical methods. All things marvellous and to the advancement of our art and craft! I realize, when I read any medical journal or special monograph, how utterly beyond acquisition by one man has become the field of medical knowledge. Well, one accepts that only a restricted field of work is possible; hence we rightly

have specialism. But specialism may go too far and breed water-tight compartment practitioners who devote their whole mind to the contemplation of the navel, to the narrowing of their outlook on the body as a whole. Specialism, therefore, should not be engaged in too early or without a good deal of general work.

I note, too, a kind of oscillation in the conduct of medical education between extremes—either a comparative aloofness of systematic academic teaching from the practical instruction of a clinical school in the hospital, or, as is proper, their close association. I think happily here the latter arrangement prevails.

University systematic lectures are now less set solemn prelections, and have not quite the same weight and importance as in the past.

Within limits I am glad that this is so. I myself never learned anything from, say, a set lecture in anatomy, but I still like the systematic delivery of lectures on medicine and surgery. Text books are usually too vast and soulless to be comfortably and profitably absorbed by a final year medical student. I specially exclude Osler's earlier editions, which are instinct with the imprint of his vibrant and convincing personality. Nor do I approve of the compressed "tabloid" type of text books. They are difficult to remember, for their dry bones are invested by no personal flavour of an arresting kind.

But really good lectures, in which a man of experience, with the teaching gift, has embodied his life's experiences and can give it to his audience in a palatable guise, are really quite as good as almost any text book, and suffice for examination needs, and for the purpose of giving the student a good all-round view of his subject.

I specially like the close affiliation of purely ward work with the daily use in the proper place of all the ancillary subjects to which I have already referred. I might well enlarge on this matter and deal with the various other compartments of medicine, notably pathology and bacteriology, for in truth now more than ever are these two subjects closely linked to clinical work of all kinds, and only with the close and convenient application at the hospital can sound, practical bedside work be done, either in diagnosis or treatment.

If the progress of this hospital in the next forty-seven years is as great as during the equal period in which it has existed, I wonder what changes it will witness within its walls and in the world of medicine.

I doubt if mere operative dexterity will rise much higher. I doubt if regions and lesions at present untouched by therapy, operative or otherwise, at least not successfully so, will be dealt with surgically with much greater success than at present. But I am ready to believe almost any possibility of progress in diagnosis and new forms of therapy, preventive or curative. Who, forty years ago, imagined such things as X rays, wireless telegraphy

or radium, to name only three developments of physical or chemical investigation? It is more than likely that cancer and tuberculosis, to name only two common scourges of humanity, will be prevented or cured, in as ample a measure as, say, enteric or yellow fever, diphtheria or small pox. May these things be.

Reports of Cases.

CHRONIC VOLVULUS OF THE SIGMOID.¹

By T. M. FURBER, M.B. (Sydney),
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Hospital, Sydney.

I wish to present two patients with chronic volvulus of the sigmoid with the notes of another case.

This man, T.N., forty years, was admitted to hospital on May 10, 1930, and stated that five days before he had abdominal discomfort and mild diarrhoea with watery motions, but no actual pain. In spite of the free bowel action the abdomen became progressively distended. The bowels had not acted nor had he passed flatus for two days before admission. He vomited once after taking castor oil. He had been operated on in England two years before for intestinal obstruction, but did not know what was found or done. For some years he had suffered from looseness of the bowels and bleeding piles.

He did not look ill, in spite of an enormously distended abdomen with visible peristalsis of a peculiar massive type, which I can now recall seeing in the other two cases. I found no cause for the obvious intestinal obstruction, but hazarded a guess that it might be due to chronic volvulus of the sigmoid.

This turned out to be the cause of the trouble, the sigmoid being some fifteen centimetres (six inches) in diameter, with walls either hypertrophied or swollen, or both, to a thickness of six millimetres (a quarter of an inch). The bowel contained only gas, not faeces, with which one of the other colons was loaded. At the base of the meso-sigmoid there was an area of thickened peritoneum, which seemed to be caused by a long-standing twist of the sigmoid through 180° from left to right. It has been suggested that this was really the cause of the trouble by contracting the meso-sigmoid and so providing a short parietal attachment for the bowel to swing on.

As signs of toxic absorption were little in evidence I resected the redundant bowel, some 90 centimetres (three feet) in length, restored the continuity by a lateral anastomosis, adding a caecostomy as a safety valve. The post-operative course was uneventful.

The second patient, J.T., was sixty-nine years old when he was admitted to hospital on January 30, 1925, as his bowels had not acted for seven days. He had suffered from constipation and prolapsing piles for years. Five days before admission he gave himself an enema without result and two days later he called a doctor who gave him three enemata also without result. The abdomen became progressively distended, but he had no severe pain. The abdomen was greatly distended and showed visible peristalsis, but there was nothing to indicate the cause of the obstruction.

Feeling sure that the obstruction was in the lower part of the colon, I made a right lumbar colostomy, as I thought that, in view of his age, it was wiser to do as little as possible consonant with saving his life.

I should like to draw your attention to this operation, which I first saw Sir Alexander MacCormick use and which has, I consider, fallen into unmerited disuse. Its

value lies in the fact that it leaves the whole of the anterior abdominal wall clean and available for a subsequent laparotomy and provides a dependent drain for the bowel and the wound, so that, in contrast to what I have several times seen after a left iliac colostomy or caecostomy, I have not met a case of infection along the fascial planes between the abdominal muscles after lumbar colostomy. Of course, it goes without saying that one must be sure that the obstruction is below the ascending colon. This, however, is not so great a drawback as might at first appear, because apart from strangulated hernia more than 75% of obstructions are found in the left half of the colon, so that by excluding the cases which by the severity and rapid march of symptoms are obviously in the small intestine, one should seldom be at fault. If one has been misled, one is put right by seeing that the colon does not bulge into the wound on cutting the lumbar fascia, as it does when overfilled.

The normal bowel function was reestablished and at his own request he was discharged on March 15, 1925, with the colostomy still open. A month later the colostomy closed and the bowels acted daily till May 25, 1925, when similar trouble to the previous attack came on and he was readmitted on May 30, 1925. The colostomy was reopened with immediate relief and an opaque enema was given on June 9, 1925. This was reported as follows: "The rectum and sigmoid filled normally, but instead of flowing up the ascending colon on the left side the enema ran up the colon on the right side of the abdomen till it reached the hepatic flexure, when no more of the colon could be filled." We did not realize the significance of this report till operation on June 26, 1925, revealed a chronic volvulus of the sigmoid, which was resected and a lateral anastomosis made. The subsequent course was uneventful and he was discharged on July 29, 1925. He went back to work a month later as a fitter and did his own blacksmithing and has since done a great deal of the heavier work of his trade.

The third case was that of a Greek, aged fifty, who had but little English and that was scared out of him, so that the history is poor. He showed great distension and massive peristalsis and although the bowels had not acted for four days, he did not seem ill. Operation revealed a similar condition to that of the other two patients, except that the sigmoid was loaded with scybala and the small intestine was a good deal dilated. I resected the sigmoid and did a lateral anastomosis, aspirating about two pints of fluid faeces from the small intestine, the puncture being buried. He, however, did not do well and died eleven days after the operation, when autopsy revealed to our astonishment that the small intestine wound had leaked and caused peritonitis which we had confidently excluded in our endeavours to account for his symptoms.

In the last twenty years I have been able to find only seven cases of this condition in the records of the Royal Prince Alfred Hospital, with two deaths. Curiously, two cases were in harmless lunatics from Gladsville and both patients recovered.

These chronic cases are to be distinguished from the acute ones in which the blood supply of the bowel is compromised and there are collapse, incessant vomiting, great pain and rapid march of symptoms to a fatal issue if operation is at all delayed.

The last patient reported was the first treated, so you will see that as a result of experience each patient has been better handled than the last. I thought, therefore, that it were better to let you have the facts rather than indulge in statistics and speculations. I must say, however, that the idea that the shortening of the mesentery is the cause does not appeal to me, as in all these cases it seemed to me that the inflammation was limited to the peritoneal coat and did not involve the cellular tissue of the mesentery, as one would have thought necessary to cause contraction.

In my experience the most important points in large bowel surgery are: (i) Make sure that both ends of the bowel are well supplied with blood, (ii) provide a safety valve by colostomy or caecostomy, (iii) see that there is no tension. I should also like to draw your attention to the value of right lumbar colostomy.

¹ Read at the first annual reunion of the Royal Prince Alfred Hospital Residents' and Ex-Residents' Association, October 7 to 11, 1930.

Reviews.

AN INTRODUCTION TO BACTERIOLOGY.

"THE FUNDAMENTALS OF BACTERIOLOGY," by Charles Bradfield Morrey, is a book that is not well known in Australia.¹ A thoroughly revised fourth edition has recently been published. The author states in a preface that he is convinced that students of bacteriology need a comprehensive grasp of the entire field and special training in fundamental technique before specializing in any particular line of the work.

The book is written especially for the study of the subject as it is arranged at the Ohio State University where one term is devoted to general bacteriology and during the second and third terms the student has a choice of special work in pathogenic, dairy, soil, water or chemical bacteriology. A second year may then be devoted to advanced work on any of the specialized lines. The book is intended to cover the first or introductory term's work.

The book is divided into four parts and thirty-two short chapters. The first part deals with morphology and classification, the second with physiology including disinfection and sterilization, the third with the study of bacteria by cultural and staining methods and the fourth with general pathogenic bacteria, the paths of infection, immunity and anaphylaxis. The book concludes with a chapter giving a brief history of bacteriology up to 1881.

The book serves as a useful short introduction to general bacteriology. It deals more fully with the physiology of bacteria than most of the text books used by medical students. There are many clear and useful illustrations throughout the book, most of them being from actual photographs. The whole subject is dealt with simply and clearly and made interesting to all who would care to know something about the microscopical forms of life and the methods devised for studying them. It is not a text book for medical students unless it be taken merely as an introduction to the subject, as the author intends it should be.

SPECIALISTS UNDER FIRE.

DR. MORRIS FISHBEIN has again turned his pen to satire and "Doctors and Specialists" is no unworthy successor of his other literary incursions.² Dr. Fishbein is a born observer with a keen sense of the ludicrous; he unerringly detects foibles and absurdities and portrays them with a brilliance and wit that cannot fail to amuse. In this instance the author has directed his sallies in general at the medical profession, past, present and future, and in particular at the medical specialist, that startling modern phenomenon who "knows more and more about less and less." The patient, too, with his boundless ignorance of medical terminology, comes in for a fair share of the genial satire. Dr. Fishbein is a kindly critic and laughs always indulgently, if heartily, at his victims. Caricature and exaggeration have been freely employed in this mischievous portrait gallery of medical celebrities and each reader must judge for himself as to how far the portraits are based on truth. There is no denying, however, that the end result is delightful and often irresistibly comic. The number of absurd illustrative anecdotes interspersed in the text heighten the general tone of good-natured informality; but some of them would hardly be missed and we wish at times that they were more striking in point. The style is bright and incisive and the American vernacular is freely introduced; we can imagine the Oxford English Dictionary wearing an expression of shocked surprise.

¹ "The Fundamentals of Bacteriology," by Charles Bradfield Morrey, B.A., M.D.; Fourth Edition, thoroughly revised; 1929. Philadelphia: Lea and Febiger. Post 8vo., pp. 347, with illustrations. Price: \$3.50 net.

² "Doctors and Specialists: A Medical Revue with a Prologue and a good many Scenes," by Morris Fishbein, M.D.; 1930. Sydney: Angus and Robertson. Crown 8vo., pp. 118, with illustrations by Dan Layman. Price: 5s. net.

Word play in general and puns in particular, though often most happy in effect, have become with the author almost an obsession; it is as though he were determined at all costs to get a "hit" into every sentence. From sheer exhaustion we would ask him sometimes to restrain this propensity which runs riot through the pages. Some of the puns we meet, if weakness did not forbid, would surely blush at their own ineptitude. But perhaps it is not fair to complain of trifles when we have been treated to such royal entertainment.

We are first introduced to the old time general practitioner, a genial and likeable soul who, though his medical lore is often spiced with quackery, is a master in the art of prescription writing; "to make sure of a good wallop he would inquire symptom by symptom and put something into the prescription to cover every indication." This healer of all ills is said to have possessed not infrequently a generous "bay window" which was "held in place with a twelve pound gold chain, hung east by west in the region of the umbilicus." We are told of the transition from this picturesque figure of the past to that "end product of a perfect civilization," the modern medico. Dr. Fishbein goes still further and predicts a terrifying future, when organization and mechanization will have reduced the art of medicine to a kind of factory process where the victim passes automatically through many pairs of super-efficient hands and emerges in a space of thirteen minutes with his "interior" thoroughly renovated. The surgeon is represented as the "mogul" of the profession; he is to be treated with a ceremony and awe befitting his supernatural wisdom and skill. But as a confession of human frailty we are told that even this paragon, this "final exhibit" of the profession has been known to be at fault and that the cryptic sign, "Opened by mistake," has more than once adorned a patient's bed after operation. The successful gynaecologist is defined: "He must either be inordinately handsome or ungodly ugly. He must be sufficiently different to attract the ladies and sufficiently indifferent to keep them attracted." The neurologist, the paediatrician, the oto-rhino-laryngologist, the ophthalmologist ("the great egoist or eye man of the profession") and all the other prominent figures in the specialist world receive due mention. But there is no need to say more. The man to whom "Doctors and Specialists" is dedicated, the doctor with a sense of humour, will do well to purchase this book.

Notes on Books, Current Journals and New Appliances.

THE JOURNAL OF THE COLLEGE OF SURGEONS OF AUSTRALASIA.

THE issue of *The Journal of the College of Surgeons of Australasia* for November, 1930, is to hand. The articles cover a wide range of subjects. R. Graham Brown has written a long article on the surgico-pathological interpretation of X ray appearances of diseases of the antrum of Highmore. The article is profusely illustrated by reproductions of skiagrams. This contribution is followed by one in which Professor D. A. Welsh and R. Graham Brown discuss the pathology of chronic suppurative antral sinusitis. C. W. B. Littlejohn writes on the subject of low backache. This is a subject surrounded by difficulties; the discussion in the article is both clear and helpful. H. R. G. Poate gives details of operations on the biliary tract; the line drawings are most useful. L. R. Chandler writes on so-called chronic appendicitis. Keith Inglis and E. B. Jones write on carcinoma of the kidney. R. A. Willis describes compensatory hyperplasia of an accessory lingual thyroid. M. P. Susman reports another case of Paget's disease of the penis. A report by Keith Ross of intussusception due to secondary melano-carcinoma will be of interest to all abdominal surgeons. Among the other contributions are several which are of interest from the point of view of surgical pathology.

The Medical Journal of Australia

SATURDAY, DECEMBER 27, 1930.

All articles submitted for publication in this journal should be typed with double or treble spacing. Carbon copies should not be sent. Authors are requested to avoid the use of abbreviations and not to underline either words or phrases.

References to articles and books should be carefully checked. In a reference the following information should be given without abbreviation: Initials of author, surname of author, full title of article, name of journal, volume, full date (month, day and year), number of the first page of the article. If a reference is made to an abstract of a paper, the name of the original journal, together with that of the journal in which the abstract has appeared, should be given with full date in each instance.

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PROSPECT.

THE present is the last issue for 1930, the pages of another year in the history of Australian medicine are about to be turned and people are wishing one another "a happy new year." At the present time pessimism is rife and the wish for a "happy new year" may be expressed from habit and with the feeling that there is little chance of happiness. The financial outlook of the Commonwealth is certainly gloomy and is the occasion of much serious thought and not a little worry to the financial experts of the community. Every State is feeling the pinch and every individual is considering ways and means of balancing his own particular budget. It is not a function of this journal to inquire into the reasons for financial stress, to analyse the value of imports and exports, to go into the question of production and payment, the making of inordinate profits or the estimation of a living wage. It is the function of the journal, however, to preach a doctrine of toleration, of self-sacrifice and cooperation. The medical profession is concerned with the physical well-being of the people, and not only their physical status, but also their mental outlook. If people are not properly fed, if they are not properly housed, if their energies are dissipated in a hopeless

and unequal struggle for existence, they will be neither well nor happy and the *corpus sanum* demands the *mens sana*.

If we turn from the community life to the world of medicine we can find grounds for pessimism. We talk glibly of medical progress, we publish books on recent advances in various subjects, we point proudly to the longer expectation of life, and claim that it is due to progress in preventive medicine, but if we look at the whole subject we must admit that for all our expended energy there is comparatively little to show. We sit for a while in the reflected glory of a successful investigator or preen ourselves for the prowess of another; and we are blind to the great areas as yet unexplored. Again, in the world of practice materialism has in some quarters gained the upper hand and in proportion as this has happened, the scientific ideal has been lost.

But enough of pessimism. A pessimist has been described as a man who sees a difficulty in every opportunity. An optimist has been described similarly as one who sees an opportunity in every difficulty. The definition may not be complete, but it is sufficient for the present discussion. The keynote for the future must be watchfulness and hope, a striving after the recovery of lost ideals and a turning in the direction of advance. Let the aim be high. It is better to fall short of attaining a high objective than to run in a groove to mediocrity. It may be claimed that all medical investigators cannot be either a Banting or a Best, and that every clinician cannot be a James Mackenzie. This is, of course, true; if it were not, we should have to alter our ideas of mediocrity. Every investigator and every clinician can, however, be actuated by the same spirit that actuated Banting, Best or Mackenzie. Brought down to everyday work, each medical practitioner, be he specialist or general practitioner, can investigate the condition of every patient with the object of satisfying himself of the ætiology of the condition, of understanding its pathogenesis, of recording his findings and of undertaking measures for its prevention, before he undertakes treatment or thinks of his own remuneration. The scientific ideal can be carried

into every clinical examination. In proportion as this is done, differences will be forgotten, enmities will be lost sight of and cooperation will be the order of the day. A united medical profession, actuated by high ideals, cannot fail to be an inspiration to the rest of the community. Only if the medical profession is united in its ideals will it be able to preach the toleration, self-sacrifice and cooperation already mentioned. Without question these qualities are those which will help the people of Australia in the new year. They will breed hope and determination. Browning may be taken as a model when he described:

One who never turned his back but marched breast forward,
Never doubted clouds would break,
Never dreamed, though right were worsted, wrong would triumph,
Held we fall to rise, are baffled to fight better,
Sleep to wake.

It is in this spirit that we wish our readers a happy and progressive new year.

Current Comment.

ALBUMINURIA OF PREGNANCY.

PERHAPS some of the mystery enshrouding the albuminurias of pregnancy would be removed if kidney function were more clearly understood. But this is a problem over which the wisest physiologists disagree. Pregnancy has often been cited as a useful test of kidney function. It is a good test, though it is not universally applicable, and few people would care to be subjected to it for the sake of satisfying a curiosity concerning the condition of their kidneys. It is not without fallacy, however, as there can be little doubt that kidneys whose function was normal before pregnancy, may become sadly deranged during pregnancy and may return to normal after parturition. Perhaps, in the study of albuminuria of pregnancy, too much attention has been given to the organs which are so obviously affected and too little to the metabolism generally. The urine provides the first indication that anything is amiss and affords a ready means of watching the progress of the condition; no doubt on this account the disturbance of kidney function has too often been regarded as the beginning and end of so-called albuminuria of pregnancy. Of course, it is known that the cardiac musculature is apt to suffer, that some degree of anæmia is common and that the nutrition is frequently affected, but these manifestations are often regarded as secondary only to the kidney affection.

There is a great strain imposed on the physiology by the necessity for the excretion of both foetal

and maternal waste products. It has been commonly suggested that albuminuria results when this strain proves too great for the kidneys' efficiency. Such a theory is, of course, too vague and fails to explain why some apparently normal women become affected and others not, nor why the condition is commoner during the first pregnancy. The strain on the organism is no greater then than during later pregnancies. The rapid advances constantly being made in biological chemistry may shed some light on the problem.

F. G. Browne and Gladys H. Dodds have recently reported the interesting results of their investigations into the association of occult nephritis and albuminuria of pregnancy.¹ In 1922 Kellogg applied the term "recurrent toxæmias of pregnancy" to an affection of kidneys which, apparently normal between pregnancies, give evidence of embarrassment of function during each pregnancy. Stander and Peckham describe a condition which they designate "low reserve kidney," a term which is self-explanatory. Young believes that in these women there is a morbid influence which he terms an "X factor"; this "X factor" is not inconsistent with good health between pregnancies, but during pregnancy it effects some placental damage which he regards as the cause of eclampsia. Though he is ignorant of the nature of the "X factor" he suggests it may be a toxin produced by an infective process such as endometritis, cervicitis *et cetera*. Browne and Dodds point out that this argument has an obvious flaw, for eclampsia and placental damage are most common in *primiparae* who are least likely to be affected by such infections.

Browne and Dodds treated twenty-nine rabbits by successive intravenous injections of sodium oxalate solution or subcutaneous injections of uranium nitrate solution. In every instance the drugs caused an acute nephritis and some greater or less degree of chronic kidney damage. Histological examinations revealed pronounced interstitial changes in the cortex. The urine of the control animals, observed during seventeen pregnancies, was regularly examined; during each of three of the pregnancies a trace of albumin was observed in the urine on two separate occasions only. No abnormality was found *post mortem* in the kidneys of the control animals. The urine of sixteen nephritic rabbits contained albumin during the latter part of each pregnancy, but not during the intervals between pregnancies, nor during the early part of pregnancy. Other rabbits passed albuminous urine intermittently in the intervals between pregnancies and the early part of pregnancy and constantly in the latter part of pregnancy; others had no albuminuria either during pregnancy or in the intervals between pregnancies. In no instance was the blood urea content raised above normal at the commencement of the pregnancy.

¹ *The Journal of Obstetrics and Gynaecology of the British Empire*, Autumn Number, 1930.

It has been noted that when chronic renal damage exists, albuminuria is likely to occur earlier in each successive pregnancy. Browne and Dodds believe, however, that this is not an invariable rule. Some of the rabbits used in their experiments actually became affected later in successive pregnancies; the urine of one contained albumin during the first two pregnancies, but none during the three pregnancies following. The interval between this animal's pregnancies was considerably longer than is usual. Even more striking is the history of one rabbit which was affected with albuminuria later in the course of its fourth pregnancy than in its three earlier pregnancies and not at all in the intervals between pregnancies; histological examination of its kidneys revealed the appearances of advanced interstitial nephritis. It must be mentioned here that MacNider and Helms found, by experiments on dogs, that kidneys which had been damaged by uranium nitrate might completely recover functionally and anatomically. Browne and Dodds suggest that such recovery could only have followed acute nephritis, though they admit the possibility that long intervals between the pregnancies of two of their rabbits may have allowed the kidneys to recover to some extent.

Browne and Dodds suggest, as a result of their observations, that the so-called "recurrent toxæmias of pregnancy" are due to a chronic nephritis which only causes obvious symptoms when the kidneys are labouring under the added load of pregnancy. They think that the "low reserve kidney" of Stander and Peckham is probably of a similar nature.

The value of tests of renal function has been freely questioned recently. Some observers have remarked that it is doubtful whether they are of any real value save when the kidneys are extensively damaged. Browne and Dodds found no evidence of faulty renal function in their rabbits between pregnancies. But little is definitely known concerning the normal chemistry of human body fluids and tissues, and he would be courageous indeed who at this stage would set up a standard of normality for laboratory animals. The results of their experiments are of great interest, but they do not help the obstetrician in his efforts to forecast the effect of pregnancy upon kidneys which respond normally to the tests in use at present. If it is true that tests for renal function are valueless excepting when the kidneys are affected with advanced disease, it is obvious that chronic nephritis may often be unrecognized and, as Browne and Dodds suggest, may possibly often be the cause of albuminuria of pregnancy. On the other hand, it cannot be too frequently or too strongly emphasized that the results of experiments on animals under unnatural conditions are not always indicative of the natural process of disease affecting human kind. It is unnecessary to mention the many possible sources of error in these experiments in which caged animals were poisoned by the administration of noxious drugs.

Browne and Dodds have barely touched the fringe of this mysterious field of the ills of pregnancy. They make no mention of the possibility that other organs may have been affected. No doubt the toxic substances used in their experiments had deleterious effects on other organs beside the kidneys and thus also the body metabolism generally. Possibly lesions in distant organs may have played a more important part in the causation indirectly of albuminuria than did the kidney lesions themselves.

Special Articles on Diagnosis.

(Contributed by Request.)

XXV.

PSYCHOSES IN THE EARLY STAGES.

WITHOUT entering into the difficult question of the exact definition of insanity or of the delimitation of the borderlines between normality and abnormality, it may be conceded that certain symptoms and signs may be recognized as the precursors of disorders of conduct involving a profound disturbance of the individual's relation to his environment affecting one or more mental functions. "By insanity of mind," said Maudsley, "is meant such derangement of the leading functions of thought, feeling and will, together or separately, as disables the person from thinking the thoughts, feeling the feelings and doing the duties of the social body in, for and by which he lives."

The early recognition of the psychoses is of practical importance not only from the standpoint of early treatment and the possible avoidance of severe developments necessitating certification, but also in order that unusual behaviour should not be regarded either by the medical practitioner or by the relatives as the manifestations of indolence or perversity when suitable treatment can alleviate if not cure the condition. The primitive, deep-rooted antipathy towards a disabled member of the herd persists in human nature and still finds expression against the mentally disordered. It may be recalled that in Butler's "Erewhon" fits of temper and moodiness were treated with the tolerance and skilful treatment usually meted out to physical illness, while the common cold was visited with castigation on the grounds that the patient had offended against the laws of health.

The symptoms and signs of the psychoses may be classified under two headings.

The first heading includes those indicating defect of the highest functional level, for example, failure of accurate discrimination of self and object and of the accurate reference of events to time and place. Such symptoms as failure of concentration (attention), sense of unreality, forgetfulness, inability to make decisions, may be early signs of a dissolution of functions which may progress to the severity of delirium, confusion or of permanent intellectual deterioration. Dreams, phantasy building, hallucinations and delusions are lower level types of mentation resulting from loss of higher control and failure of the critical faculty. In *dementia præcox* there may be observed the downward trend from mere failure of attention through the stages of dreaminess and phantasy to delusion formation and finally apathetic mindlessness or dementia.

The second class of symptoms results from decontrol and hyperactivity of the emotional-impulsive level (probably thalamo-striate). As examples may be given the abnormal mood swings of the manic-depressive psychosis, the impulsive actions, stereotyped movements and peculiar attitudes of *dementia præcox* and the perverted gratification of instincts by stealing, hoarding of rubbish and sexual activities in senile dementia and other psychoses.

The clinical syndromes usually described in text books are compounded out of these two groups of symptoms,

namely, those due to failure of the highest or intellectual level, and those which are expressions of the lower and now uncontrolled levels of instinct, emotion and impulse. Moreover, the different morbid reactions are varied according to the degree of maturity attained by the organism, so that age periods tend to have their own symptomatology.

The Psychoses of Adolescence.

The incidence of insanities is negligible during the first ten years of life. The second decade, on the other hand, is a period of special stress owing to the profound physical and mental changes of puberty and adolescence. Rapid growth, the awakening of the sexual instinct stimulated by the activity of the gonads and other endocrine glands, the special demands of education and the social adjustments involved in leaving school and perhaps home in order to enter upon some vocation may throw too great a strain upon the individual with a poor psycho-physical endowment. Statistics of insanity, calculated from the percentages of the general population at various age periods admitted for the first time to mental hospitals, show a sharp rise during the second decade and thereafter a more gradually increasing incidence up to the age of forty. After fifty again there is a rapid rise. No doubt were figures available regarding milder conditions treated at home, the so-called neuroses, a similar graph would be produced. The frequency of hysterical episodes in adolescence, especially in females, is, of course, well recognized. During adolescence there also appear the first manifestations of the two important biogenic psychoses whose ætiology is essentially hereditary and constitutional, namely *dementia præcox* and the manic-depressive psychosis. From a wide experience Kraepelin stated that more than half the cases of *dementia præcox* begin before the age of twenty-five, while in the manic-depressive psychosis the majority of the first attacks occur between the ages of twenty and thirty-five.

The adolescent may display instability which causes his parents and his medical attendant grave concern. Moodiness, capriciousness, emotional outbursts, obstinacy, intolerance of discipline and freely expressed disapproval of the advice and guidance of elders sometimes occur as unexpected developments, but perhaps more often as the exaggeration of existing attributes of the personality. It is of interest to note that the lowered inhibitions and the urgency of instinctive demands associated with this period are not only responsible for mental disorders, but are reflected in a similar rise in the incidence of delinquency and criminality. Frankly, a diagnosis can rarely be arrived at without observing the patient over a period of time. Mental symptoms are the resultant of a number of factors such as heredity, constitution, the physiological and psychological stresses of various age periods and the noxious influences in the physical and psychological environment (for example, infections, nutrition, occupation, upbringing, companionship, the domestic setting). Without further investigation it is not possible to decide how far instability is of internal origin or to what extent it may be a reaction to an intensely irritating and difficult situation. It may be taken as an axiom that the less severe the external, environmental factors, the greater the probability that instability is a sign of one of the psychoses to be described, with a graver prognosis.

It may be recalled that Kraepelin who was responsible for a classification of mental disorders which has been widely adopted, delimited the two great groups of constitutional psychoses, *dementia præcox* and the manic-depressive psychosis, by including in the former cases which progress to mental deterioration and in the latter cases with recurrent, phasic psychoses unaccompanied by mental impairment.

Dementia præcox and schizophrenia are the terms generally applied to a deteriorative psychosis which begins usually in the second decade. The fully developed psychosis is characterized by three main features, one or more of which may be recognized as a morbid trait in the personality long before there is any serious social maladjustment. These features are introversion, incoherence and paranoid trends. A good deal of attention has been paid, especially by American psychiatrists, to the "pre-psychotic"

personality in *dementia præcox*. The introvert features which call for special study and guidance in childhood and which, considered retrospectively, are of value in diagnosis, have been clearly described by the late August Hoch ("Review of Neurology and Psychiatry," 1928):

We find in *dementia præcox* persons who have not a natural tendency to be open and to get into contact with environment, who are reticent, seclusive, who cannot adapt themselves to a situation, who are hard to influence, often sensitive and stubborn, but the latter more in a passive than an active way. They show little interest in what goes on, often do not participate in the pleasures, cares and pursuits of those around them; although often sensitive, they do not let others know what their conflicts are, do not unburden their minds, are shy, and have a tendency to live in a world of fancies.

These "shut-in" traits cause such individuals to avoid contact with their fellows so that they miss the rivalries and competitions of sport and other social activities which might evoke qualities which must otherwise remain latent and undeveloped. The personality thus remains poorer for the lack of healthy stimulation and morbid interests and cravings, including sexual perversions, are apt to follow. Thus it comes about that these psychopaths, having attained years of discretion chronologically without adequate mature development of the personality, fail in making some important social adaptation, shrink further into themselves in the face of some responsibility and after passing through a phase of despair and panic, sink to the lower level of phantasy and delusion formation. In the psychosis introversion takes the form of apparent complete indifference to environmental demands (mutism and general inertia) or active antagonism to external interference (negativism and aggressive behaviour).

The second feature, incoherence, is a defect of the association of mental processes. In the pre-psychotic stage it is often noted that the patient has displayed a peculiar dreaminess and vagueness of mentation, a lack of the capacity for steady, systematic application to his studies and for well directed logical thought. Relative and often spurious success in literary studies may have been offset by a surprising weakness in mathematics. Yet by ordinary standards there is no true mental deficiency. The emotional responses are often out of keeping with the situation and cause the adolescent to be called "hysterical," childish or silly. In the psychosis this incoherence or, to use the terminology of the text books, schizophrenia (splitting of mind) or "intrapsychic ataxia" is responsible for the confused, disjointed utterances, irrelevant remarks, and the incongruous emotional display which are so striking in *dementia præcox*. Kraepelin indeed spoke of "the loss of the inner unity of the activities of intellect, emotion and volition." The conduct of the schizophrenic is meaningless, unexpected and inconsistent. By contrast the manic or the melancholic thinks and acts for weeks or months on end in accordance with his exalted or depressed mood.

Paranoid trends develop out of a strong sense of inferiority and may be considered as a reaction to the introvert disposition. Lack of self-confidence is often combined with suspicion and distrust of the intentions of others. By means of projection, one of those mechanisms by which an individual attempts to preserve his self-esteem by blaming any and everybody but himself, the psychotic looks outside himself for the causes of his failures. All that is displeasing in himself is exteriorized so that he comes to look upon himself as the victim of a hostile world. Malign influences, telepathic or electric, and gases and voices assail him wherever he goes. As mental deterioration progresses the hallucinations and delusions become more far-fetched and absurd.

In *dementia præcox* there may usually be obtained a history of an insidious change in disposition, taking the form not only of an exaggeration of the morbid traits already mentioned, but more widely of a gradual loss of initiative and ambition and of a steady decline in efficiency. The patient holds one position after another until finally he becomes unemployable. Sometimes a deterioration of sentiments, a loss of self-respect and a

gross lack of regard for the rights and feelings of others, with actual moral lapses, precede the definite psychosis. Relatives report that the patient has "gone to the pack" and become delinquent, alcoholic or vagrant. In other cases a phase of phantasy building, unorthodox speculations in science, philosophy, art and ethics, or an excessive devotion to religious exercises with ecstatic professions may be precursors of an established psychosis. Often the observer is in doubt as to how far such symptoms remain within the bounds of what may be considered a normal readjustment of values and sentiments in adolescence. Neurotic symptoms, unusual fatigability, anxiety, obsessions and emotional display should not be regarded too lightly in adolescence and any indication of resistance and lack of cooperation on the part of the patient and apparent indifference to the illness and emotional blunting should be taken as warnings of a developing psychosis.

The acute forms of *dementia præcox*, catatonic excitement, depression and stupor are less frequent and need not be dealt with here in detail. They may be preceded by the symptoms already described or develop suddenly after a few days' restlessness, insomnia and other indefinite symptoms.

In no psychosis is it more important to take a long view of the case, to take into consideration the personality of the patient and the gradual changes which occur in his disposition and behaviour.

Manic-Depressive Psychosis.

The main features of manic-depressive psychosis are: (i) The exaggeration of mood in the direction either of exaltation or depression, (ii) occurrence in attacks with intervals of normality and (iii) absence of intellectual deterioration. In many cases there is a history of emotional instability, excitability and restlessness, or of depressive and hypochondriacal trends, even in childhood. During adolescence there occurs a more definite cyclothymia, the tendency to abnormal oscillations of mood, culminating in an attack of acute mania or melancholia. All gradations are met with between the normal and the psychotic.

Mania.

Early and mild symptoms of mania are restlessness, tireless activity, which may or may not be well directed and result in useful achievement, extravagance in thought, speech and action, and an exalted egotism. The list might be multiplied indefinitely, but the importance of such symptoms lies in their occurrence in a cyclothymic setting or as a definite change in the personality. Free indulgence in alcohol, excess of *libido* and financial speculation are apt to lead the patient into difficulties and may render certification desirable. These patients are often intolerant of any attempted check on their activities, their morbid self-satisfaction is incompatible with an admission of ill health, while their plausibility may render certification most difficult. Frequently the psychosis must be allowed to reach the acute stage before the patient can be placed under restraint.

Melancholia.

The principal features of the fully developed melancholic psychosis are depression and psychomotor retardation. As in mania there is every gradation from the mild forms which have a "neurasthenic" symptomatology, up to acute melancholia. The incipient phase usually takes the form of a sense of incapacity, inability to concentrate and sense of mental effort combined with general fatigability. At first these symptoms are largely subjective and lead the patient's relatives to urge him to greater effort and to seek distraction in ways which make too great demands upon his dwindling energy. Morbid anxiety and obsessions may also be prominent features. Broken sleep, terrifying dreams, fears regarding mind, body and estate, associated with vasomotor instability make up an adequate picture of "anxiety neurosis" for a time. A provisional diagnosis of "obsessional neurosis" may also be made with some justification. These prodromal symptoms are due to failure of the highest (cortical) level. Though rest, adequate nutrition, sedatives and other methods of treatment instituted at an early stage doubtless check further

developments in many instances, the emotional component often becomes more intense (release of lower thalamostriate level) and depression dominates the clinical picture. Moreover, the "functional" disturbances of various bodily systems are responsible for symptoms. Failure of the secretions, lacrymal, salivary, gastric, intestinal and genital, may each and all be a source of distress to the patient and may lead the medical attendant to direct his therapeutic efforts too locally, overlooking the general setting in which such symptoms occur. A detailed history will disclose the phasic character of, for instance, a gastrointestinal disorder. Appendectomy, colexomy, pelvic operations have been performed before now, often at the patient's urgent request, for the relief of temporary melancholic symptoms. In the diagnosis of functional disorders with a depressive affect special attention should be given in taking the history to cyclothymic tendencies and previous "attacks" of neurosis and psychosis. Any change in disposition should be noted, especially increasing proneness to worry and magnify difficulties. That which patients and friends allege as a cause for the depression is rarely an unusual or excessive stress, judged by average standards. More often the patient's growing incapacity prevents him from dealing squarely with his ordinary responsibilities. A careful physical examination is, of course, most important, for depression may result from severe organic disease (*vide infra*).

Differential Diagnosis of the Adolescent Psychoses.

Admittedly the diagnosis between *dementia præcox* and the manic-depressive psychosis may remain in doubt for a time, and mixed forms occur. The more prominent is the exaggeration of mood and the more thought and action are in keeping with it, the more certainly is the psychosis manic-depressive.

Juvenile Paresis. The early symptoms of juvenile paresis may be mental, taking the form of a gradual change in disposition not unlike that which occurs in *dementia præcox*. Less frequently there may be excitement or depression. Signs of congenital syphilis are not always present, but neurological signs eventually appear and may be confirmed by serological examination.

Epidemic Encephalitis. In the acute stage of rowsiness a diagnosis of catatonic stupor may be considered. But the mode of onset, a history of diplopia and the presence of ocular palsies and other neurological signs, also of delirium and pyrexia, should be noted. The sequels create more difficulty. A patient complains of increasing difficulty in exercising his mental faculties and of a sense of unusual physical effort, symptoms about which he is much concerned. The friends note that he is becoming slow in speech and action. Some months later the Parkinsonian syndrome is unmistakable. Quite early in this condition, when "neurasthenia," "melancholia" or even *dementia præcox* may be diagnosed, a defect of ocular convergence may be demonstrated before other physical signs and the exhibition of hyoscine or stramonium has almost a diagnostic value.

Encephalitis is also responsible for extraordinary character changes, such as restlessness and indiscipline, like the mild mania of adolescence, but also accompanied by a gross loss of moral sense. These patients may perform outrageous offences against society, such as incendiarism, mutilation of animals and homicidal acts, and yet fail to be influenced by severe punishment. This has appropriately been termed the "apache" form of encephalitis. Physical signs are usually mild, often absent and many patients appear never to have had an acute illness.

Psychoses of Involution.

The psychoses of the period of involution, which may be said to begin with the waning of *libido* (forty onwards in women, later in men) include the biogenic psychoses and also those due to syphilis, alcohol, renal and cardiovascular disease, diabetes, subthyroidism and other physical disorders which tend to occur in the later years of life.

Paranoid States. Occasionally quite typical cases of *dementia præcox* have a late onset. In these the paranoid

element is usually prominent. *Dementia præcox*, *paraphrenia*, *paranoia* may all be classed in the same group, the differences between them depending on the degree of stability and maturity of the individual when the psychosis begins. *Paraphrenia* and *paranoia* are disorders of maturity. Both develop on a basis of an introvert personality and a prolonged phase of morbid sensitiveness, lack of adaptability to social conventions and demands, suspicions and of "taking things the wrong way" may be observed in most cases. The evolution of these paranoid psychoses extends over years and the patients are notoriously uninfluenced by treatment. Most often the medical attendant is consulted by the friends when the psychosis is already well established. Medico-legal complications may occur at any stage, but unless there is a free expression of delusions a plea of irresponsibility can rarely be substantiated.

Manic-Depressive Psychosis. The cycles of this psychosis may develop or recur at any age. The manic phases preserve a fairly constant type, whereas depression in the involutional period has a more special symptomatology. Morbid anxiety, apprehensiveness and agitation, with intense hypochondriacal symptoms dominate the picture. The revival of depressive memories also takes a large place in the patient's mental operations. An adolescent melancholic rarely harps upon the "sins" of his childhood, whereas in the involutional period the depressed patient dwells remorsefully on the mistakes of his youth. The prodromal phases are similar to those already detailed.

Some Physical Diseases. Cerebral syphilis and *dementia paralytica* which account for some 10% of insanities in men of middle age, have already been dealt with in previous articles in this series by Dr. A. W. Campbell, Dr. R. G. Williams and Dr. H. F. Maudsley.

Serological examination is specially important in the psychoses of involution owing to the varied clinical pictures presented by neurosyphilis.

Renal Disease. The first symptoms of renal failure may be mental. Deep depression, with suicidal impulses, restlessness, insomnia and peculiar cutaneous sensations may be the first warnings of uræmia. Occasionally a patient may pass through a stage lasting days or weeks in which he displays paranoid symptoms. He becomes increasingly suspicious and develops persecutory ideas, often with hallucinations. Delirium and confusion, sometimes with extreme excitement, are then followed by the terminal state of coma.

Diabetes. Diabetes may be responsible for depression and irritability and other symptoms of a "neurasthenic" character. The depression may be sufficiently intense to lead to suicidal attempts. In the absence of treatment confusion and coma are apt to supervene.

Subthyroidism. Subthyroidism may be responsible for inability to concentrate and mental fatigability, depression, increasing dulness and apathy, progressing to vegetative dementia. The occurrence of such symptoms in the involutional period merits the administration of thyroid extract, even though the physical signs of myxœdema are not obvious. Diagnosis may be assisted by estimation of the basal metabolism.

Alcohol. Alcohol takes an important place in the psychoses of middle age, though how far indulgence is truly causative and how far symptomatic is difficult to decide. "Alcoholic" delirium, confusion, depression, excitement, *paranoia* and *dementia* are described in most text books. Coarse lingual, facial and digital tremors, gastro-intestinal disturbances and other physical signs of chronic alcoholism assist in the diagnosis when a reliable history is unobtainable. However unfavourable the mental picture, the diagnosis and prognosis should be kept open until a suitable period of abstinence has elapsed or until physical signs of toxæmia have disappeared.

Epilepsy. Epilepsy has confusional, excited, depressive, stuporose and other sequels and "equivalents." These episodes are usually transitory, lasting a few hours or days. The history of major or minor attacks is, of course, of importance.

Confusional Psychoses. An article on mental disorders would be incomplete without mention of confusional

psychoses. Yet it is difficult to be dogmatic about the early diagnosis. Confusion is usually a sequel of infection, inorganic and organic poisons, cerebral circulatory disturbances, organic brain disease and other physical disorders, some of which have been described above. In other cases increasing exhaustion follows child-birth and other physical and mental stresses. Loss of sleep, appetite and weight, a "toxic" appearance and mental incapacity in the form of inability to concentrate and ready fatigability may be taken as warnings that a confusional psychosis is likely to develop. The features of the acute psychosis which occurs at all ages are a clouded consciousness, loss of awareness of time and place, mistaking of identities and fleeting and changing hallucinations and delusions. Emotional instability and motor excitement may be present. Again, dissolution and decontrol are responsible for the clinical picture.

Dementia.

Advancing age is accompanied by an increasing liability to mental deterioration. The prognosis regarding mental disorders in the later years of life should therefore be guarded. A gradual failure in capacity may at first be overshadowed by depression or by some neurotic syndrome, less frequently by a phase of excitement. Paranoid trends are not uncommon. After observation for some weeks or months it is noted that the patient has become self-centred and that he is showing a limited comprehension and retention of new impressions which is quite out of proportion to the depression. Sooner or later the defect of memory is displayed in the mislaying and losing of personal belongings, the inability to recall recent domestic events and in the tedious reiteration of some topic of conversation, due to a fixity or inertia of mental processes. In writing a letter the patient is apt to make significant mistakes in spelling and syntax. The memory defect often leads the patient to accuse his family of deliberate deception and dishonesty. With the dissolution of the higher mental functions there is a regression to childish behaviour ("second childishness and mere oblivion") in the form of dependency on others, childish interests, even to the extent of engaging in childish amusements, and of reactivation of memories of early years (dwelling on the past). As deterioration progresses there may be actual neglect of personal appearance and hygiene. The lower emotional and instinctive mechanisms are decontrolled. Emotional lability, petulance and irritability are common features and the instincts of acquisitiveness and sex may be gratified in defiance of social conventions (hoarding of rubbish, stealing, indecent exposure and sexual assault). The diagnosis is supported by physical evidence of senility. *Dementia* is, of course, a common sequel of cerebral vascular lesions. Occasionally delirium or confusion may precede the mental deterioration.

W. S. DAWSON, M.D. (Oxon), M.R.C.P.
(London),

Professor of Psychiatry, University
of Sydney.

British Medical Association News.

ANNUAL MEETING.

THE ANNUAL MEETING OF THE QUEENSLAND BRANCH OF THE BRITISH MEDICAL ASSOCIATION was held at the B.M.A. Building, Adelaide Street, Brisbane, on December 12, 1930, Dr. S. F. McDONALD, the President, in the chair.

ANNUAL REPORT OF COUNCIL.

The annual report of the Council was taken as read and adopted on the motion of Dr. W. N. ROBERTSON, seconded by Dr. J. LOCKHART GIBSON.

The Honorary Treasurer presented the financial statements which were adopted (see pages 860-862).

The Council has pleasure in presenting the following report of the Branch for the year ended November 15, 1930.

Membership.

The present membership of the Branch is 481, as against 475 last year, making a net gain of 6.

The additions have been: Elections of new members 12, paid arrear of subscription 1, transfers to the Branch 24. The losses have included transfers from the Branch 19, default in payment of subscription 10, deaths 2.

The Council regrets to record the deaths of Dr. John H. S. Jackson and Dr. Henry L'Estrange.

Meetings.

General.

The annual meeting and ten ordinary meetings of the Branch were held during the year, including one clinical meeting. The average attendance was 43.

Four extraordinary meetings were held as follows: Ratification of amendment of By-Laws of the Branch; two meetings to consider the question of the Royal Commission on Hospitals; and consideration of the matter of specialist services for lodge members.

Council.

The Council held twenty ordinary meetings and four special meetings. The special meetings were held in connexion with the Royal Commission on Hospitals and to deal with an ethical matter.

Dr. Hedley Brown was granted leave of absence from the beginning of March until November whilst on a trip abroad.

Dr. Alex Murphy was appointed Chairman of Committees and Dr. N. W. Markwell Assistant Honorary Secretary.

The record of attendance of members of the Council was as follows:

	Ordinary.	Special.
Dr. S. F. McDonald (President)	18	4
Dr. F. A. Hope Michód (President Elect and Honorary Treasurer)	14	3
Dr. Mervyn S. Patterson (Past President)	14	1
Dr. B. L. W. Clarke (Honorary Secretary)	16	4
Dr. N. W. Markwell (Assistant Honorary Secretary)	20	4
Dr. Neville G. Sutton (Honorary Librarian)	17	2
Dr. M. Graham Sutton (Honorary Curator of Museum)	18	4
Dr. E. S. Meyers (Federal Committee Representative)	14	4
Dr. D. Gifford Croll (Federal Committee Representative)	17	3
Dr. J. Hedley Brown ¹ (Councillor)	3	1
Dr. Gavin H. Cameron (Councillor)	20	4
Dr. H. V. Foxton ² (Councillor)	10	—
Dr. Charles M. Lilley (Councillor)	16	1
Dr. Alex. Murphy (Councillor)	17	4
Dr. L. J. J. Nye (Councillor)	17	1
Dr. W. N. Robertson (Councillor)	13	4
Dr. D. E. Trumpy (Councillor)	14	2
Dr. Eustace Russell (Councillor)	13	2

Scientific Meetings.

February.—Exhibition of cinematograph film, "William Harvey and the Circulation of the Blood." Kindly lent by Dr. Rowden White, of Melbourne. A foreword on the life of Harvey was given by the President, Dr. S. F. McDonald.

March.—Dr. Eustace Russell: "The Diagnosis and Treatment of Bronchiectasis."

April.—Dr. F. A. Hope Michód: "Eclampsia and Albuminuria."

May.—Dr. A. E. Paterson: "The Diagnosis and Treatment of Tetanus, with a Report of Twenty-Six Cases."

¹ On leave whilst abroad.

² Absence due to illness.

June.—Joseph Bancroft Memorial Lecture, Dr. Gordon Craig (Sydney): "Progress in Prostatic Surgery" (with film demonstration).

July.—Dr. S. F. McDonald: "The Problem of the Pensioner."

August.—Dr. M. Graham Sutton: "Observations on the Endometrium and Uterine Hæmorrhage."

September.—Clinical Meeting, Brisbane Hospital, combined with Brisbane Hospital Clinical Society.

October.—Dr. Kenneth Wilson: "Gynæcological Notes, with Special Reference to Radium."

November.—Dr. B. L. W. Clarke: "Radiation in the Treatment of Malignant Disease."

Many interesting cases and specimens were shown at the various meetings.

Personnel of committee responsible for the programme of papers: Dr. Gavin Cameron, Dr. M. Graham Sutton and Dr. C. M. Lilley.

The thanks of the Council are extended to Mr. George Hancox for his valuable services as Honorary Lanternist of the Branch.

Library.

During the year the following books have been donated to the library: A book of cardiographs, presented by Dr. Eustace Russell; a reprint of the Memorial Service to the late Sir George A. Syme, presented by the Victorian Branch of the British Medical Association; a catalogue of scientific and technical periodicals in the libraries of the Commonwealth, compiled by the Council for Scientific and Industrial Research and presented by that body; The Australian and New Zealand Pharmaceutical Formulary, Fifth Edition, 1930, presented by the Pharmaceutical Society of Queensland.

Federal Committee.

Two meetings of the Federal Committee were held during the year, namely, March 27 and October 2. The Branch was represented by Dr. D. Gifford Croll and Dr. E. S. Meyers at the former meeting. At the October meeting Dr. Alex. Murphy took the place of Dr. Meyers, who was unable to attend. The reports of the proceedings were published in THE MEDICAL JOURNAL OF AUSTRALIA.

Australasian Medical Congress.

The fourth session of the Australasian Medical Congress (British Medical Association) will be held at Perth, in September or October, 1932.

Representation.

The Branch was represented as follows during the year:

Council of the British Medical Association: Dr. R. J. A. Berry.

Representative Body: Dr. Hedley J. Brown.

Federal Committee of Branches: Dr. D. Gifford Croll, Dr. E. S. Meyers and Dr. Alex. Murphy.

Australasian Medical Publishing Company, Limited: Dr. D. Gifford Croll, Sir David Hardie, M.D., and Dr. J. Lockhart Gibson; Dr. Croll is also a Director of the Company.

Queensland Medical Land Investment Company, Limited: Dr. F. A. Hope Michód.

Australasian Association for the Advancement of Science: At the Congress held in Brisbane in May last Dr. C. D. Gillies, Dr. W. N. Robertson and Dr. J. V. Duhig were the delegates of the Branch.

Health Inspectors' Association of Australia (Queensland) Annual Meeting: The President, Dr. S. F. McDonald.

Queensland Cancer Trust: Dr. B. L. W. Clarke and Dr. Val. McDowall (now resigned).

New South Wales Branch British Medical Association, Jubilee Functions: Dr. Alex. Murphy.

Subcommittees.

Hospital.

Personnel: Dr. E. S. Meyers, Dr. C. M. Lilley, Dr. Eustace Russell and Dr. D. E. Trumpy, and the *ex officio* members.

Twenty-two meetings were held during the year and matters relating to over twenty-seven hospitals received consideration.

The most important event was the holding of the Royal Commission on Hospitals which commenced its sittings in Brisbane on June 11, 1930, and travelled throughout the State taking evidence.

In order to obtain an authentic knowledge of the hospital position a *questionnaire* was sent to members in the country districts in Queensland. Although only fifty-two replies were received, the information obtained gave a good idea of the general position and was very useful in compiling our evidence. Dr. Cliff. Tucker rendered valuable assistance in this matter.

An immense amount of work was performed by Dr. E. S. Meyers, who was the main official witness of the Branch and his services in connexion with the Commission were much appreciated. Other witnesses of the Branch were Dr. D. Clifford Croll, Dr. Alex. Murphy, Dr. S. F. McDonald and Dr. John Bostock.

The Commissioners were Mr. William Harris, Chairman; Dr. E. Sandford Jackson and Mr. S. A. Glassey.

The scope of the Commission was very wide and the report, which should be published shortly, is awaited with much interest. It is hoped that many of the hospital problems that have been a source of trouble for years past will be solved.

With a view to protecting the interests of members of the Association who apply for positions at country hospitals, the Council is always willing to supply any information possible and a notice to this effect has been placed in THE MEDICAL JOURNAL OF AUSTRALIA.

It should again be emphasized that members who accept appointments at country hospitals would save themselves grave difficulties in the future by insisting on a written agreement before accepting a position and having the agreement considered by the Council of the Branch.

The attention of members is drawn to the fact that it has always been the policy of the Branch to oppose any domiciliary treatment in connexion with hospital appointments, unless it is carried out under the terms of the model lodge agreement.

Rules and Ethical.

Personnel: Dr. Hedley Brown, Dr. E. S. Meyers, Dr. M. Graham Sutton, Dr. Gavin H. Cameron and the *ex officio* members.

Fourteen meetings were held and many ethical questions of a personal and general nature were dealt with.

Proposed Ethical Rules of the Branch: This matter has received consideration and recommendations have been made to the Council, on which legal advice is being obtained.

Public Health.

Personnel: Dr. D. Gifford Croll, Dr. Eustace Russell, Dr. L. J. J. Nye and the *ex officio* members.

Ten meetings were held and the matters considered included the following: Proposed Ministry of Health, legislation regarding the sale and use of drugs, airlock workers, diphtheria regulations, Greater Brisbane Milk Bill, medical certificates of the causes of death, Coroners Bill *et cetera*.

In view of the Commonwealth Health Department's decision to investigate the question of chronic nephritis in Queensland, a committee was appointed from the Branch to meet the officials of the Health Department and work in conjunction with them. The personnel of this committee is as follows: Dr. D. Gifford Croll, Dr. J. Lockhart Gibson, Dr. A. Jefferis Turner, Dr. L. J. J. Nye, Dr. J. V. Duhig, Dr. Alex. Murphy, Dr. Ellis Murphy, Dr. S. F. McDonald and the Honorary Secretary of the Branch, Dr. B. L. W. Clarke.

Building.

Personnel: Dr. W. N. Robertson, Dr. D. Gifford Croll, Dr. L. J. J. Nye, and the *ex officio* members of the Council. No important developments have eventuated during the year. "Bay View," the property purchased by the Branch on Wickham Terrace, is still occupied by the same tenant.

The position of the B.M.A. Building has been improved by the completion of the new City Hall, the widening of Adelaide Street and the erection of new buildings opposite.

Parliamentary.

Personnel: Dr. W. N. Robertson, Dr. H. V. Foxton, Dr. L. J. J. Nye and Dr. Hedley Brown and the *ex officio* members.

Publicity.

Personnel: Dr. W. N. Robertson and the *ex officio* members.

Lodge.

Personnel: Dr. Gavin Cameron, Dr. E. S. Meyers and Dr. M. Graham Sutton and the *ex officio* members.

Owing to the volume of work to be dealt with in connexion with lodge contract practice, a Lodge Sub-Committee was appointed by the Council in September, to report on the Contract Practice Section Committee's reports.

Post-Graduate.

Personnel: Chairman, Dr. S. F. McDonald; Joint Honorary Secretaries, Dr. Neville G. Sutton and Dr. Keith Ross; Dr. A. G. Anderson, Dr. E. D. Ahern, Dr. D. Gifford Croll, Dr. D. A. Cameron, Dr. G. A. C. Douglas, Dr. Val. McDowall, Dr. J. V. Duhig, Dr. H. S. McLelland, Dr. Alex. Murphy, Dr. Alan Lee, Dr. E. S. Meyers, Dr. C. E. Tucker, Dr. L. M. McKillop, Dr. Graham Sutton, Dr. Ellis Murphy and the *ex officio* members.

This Committee again reports a successful year.

The annual course was held in June, the lecturers being Dr. S. V. Sewell and Mr. Alan Newton, of Melbourne. Dr. Sewell gave a series of lectures and demonstrations dealing with diseases of the heart and nervous systems. Mr. Newton lectured on surgery of the upper abdomen and demonstrated various operations at both the Brisbane and Mater Misericordiae Hospitals. Mr. Gordon Craig, of Sydney, the Bancroft Lecturer, also very kindly demonstrated urological operations at both hospitals. A film demonstration was also given during the course, namely, Kanavel film, "Infection of the Hand," kindly lent by the honorary medical staff of the Sydney Hospital, and Professor R. Marshall Allan, of Melbourne, exhibited an obstetric film, "Management of Breech Presentation" (De Lee), and gave an introduction thereon.

Dr. G. A. C. Douglas gave a demonstration on fractures of the femur at the Brisbane Hospital.

The standard of the various lectures and demonstrations was very high and members of the course were more than satisfied and have expressed their great indebtedness to the lecturers.

The number attending the course was 103, the largest number on record.

Dr. Sewell also visited Toowoomba and addressed members of the Local Association.

Lectures and demonstrations were given during the year at Warwick and Toowoomba by Dr. S. F. McDonald, Dr. G. A. C. Douglas, Dr. B. L. W. Clarke, Dr. A. S. Roe and Dr. R. Graham Brown. It is hoped to extend the scope of this work during the coming year and also to arrange a short "refresher" course in Brisbane.

An endeavour was made to arrange for the Kanavel film on "Infections of the Hand" to be exhibited in the larger centres in the State, but unfortunately it was found impossible to allow the film to remain out of Sydney for the period of time involved in the proposal.

The Committee is now being reconstituted, and as its new members will be elected for three years, it will assume a semi-permanent character.

Sections for Special Branches of Medical Knowledge.*Eye, Ear, Nose and Throat Section.*

Inaugurated 1924.

President, Dr. E. O. Marks; Vice-President, Dr. E. Culpin; Councillor, Dr. R. Graham Brown; Honorary Secretary, Dr. Walter Lockhart Gibson.

Membership, 24.

Three quarterly meetings and an annual meeting were held during the year. Cases and specimens were shown and discussed at the meetings. Contract practice as it affects specialists has been before the meetings and it is likely that some definite arrangements will be made in the near future.

Surgical Section.

Inaugurated February, 1927.

President, Dr. A. V. Meehan; Honorary Secretary and Treasurer, Dr. A. E. Lee; Committee, Dr. E. S. Meyers, Dr. H. S. McLelland and Dr. M. Graham Sutton.

Meetings: Three meetings of the Section and one extraordinary meeting were held during the year, the papers read being: "Operative Treatment of Inguinal Hernia," by Dr. M. Geaney; "Acute Pancreatitis," by Dr. A. E. Lee; and "Peptic Ulceration," by Dr. E. D. Ahern. The papers were carefully prepared and usually evoked keen discussion.

At a special meeting of the Section a scale of maximum fees for operations on lodge patients was approved and forwarded to the Council of the Branch.

Obstetrical Section.

Inaugurated November 15, 1927.

President for 1930, Dr. F. A. Hope Michod; Vice-Presidents, Dr. J. A. Cameron and Dr. A. H. Marks; Honorary Treasurer, Dr. L. W. Gall; Honorary Secretary, Dr. K. Wilson; Statistical Committee, Dr. F. A. Hope Michod, Dr. R. G. Quinn, Dr. L. H. Foote and Dr. K. Wilson.

Quarterly meetings were held in January, April, July and October, the average attendance being 15.

A short paper on the Rotunda views on contraction and disproportion was read by Dr. K. Wilson at the April meeting. The July meeting took the form of a clinical meeting at the Lady Bowen Hospital, where cases were shown by Dr. Gall, Dr. K. Wilson, Dr. Elliot-Smith and Dr. Duhig.

At the annual meeting in February Dr. A. H. Marks, the retiring President, read a paper on the use of low forceps.

Medical Section.

Inaugurated June 1, 1928.

President, Dr. S. F. McDonald; Honorary Secretary and Treasurer, Dr. T. H. R. Mathewson.

Four meetings of the Section have been held since last annual meeting, as follow:

December 20, 1929.—Dr. R. W. Cilento opened a discussion on "The Incidence of Chronic Nephritis in Queensland."

May 12.—Dr. Ellis Murphy read a paper on "Endo-cardiography in Relation to Diagnosis."

August 18.—Dr. W. H. Steel read a paper on "Pulmonary Tuberculosis with Particular Reference to Diagnosis and Treatment."

November 10.—Dr. J. V. Duhig read a paper on "Protein Sensitivity."

Contract Practice Section.

Inaugurated February, 1929.

The annual meeting of the Contract Practice Section was held on July 28, 1930, when the following office bearers were elected: President, Dr. Clif. Tucker; Honorary Secretary, Dr. H. S. Waters; Committee, Dr. A. B. Carvosso, Dr. Gavin Cameron, Dr. J. L. Selwood, Dr. L. W. Gall, Dr. D. V. Sheil, Dr. A. E. Mason, Dr. L. J. Dart, Dr. J. G. Wagner, Dr. R. J. Nash, Dr. G. A. McLean, Dr. R. A. G. Malcolm and Dr. F. W. Lukin.

Dr. Lukin was appointed Honorary Secretary in October, on the resignation of Dr. Waters.

The Contract Practice Section Committee has continued to function in place of the former Special Lodge Sub-

Committee. Fortnightly meetings have been held and reports made to the Council. Keen interest in the various problems submitted to them has been shown by the members of the Committee and on the whole steady progress has been made in getting the Federal Model Lodge Agreement adopted uniformly throughout Queensland.

A schedule of fees for the performance of operations and special services to lodge members, is under consideration.

The formation of specialist service to lodge members has been under discussion for some time. This service was asked for by the Friendly Societies' Medical and Hospital Council, as it had been previously promised to them. Correspondence has passed between the Council of the Branch and the Contract Practice Section Committee on this subject and at a combined meeting of the Council and the Committee, the matter was thoroughly discussed and a satisfactory settlement of all points under discussion was arrived at. It is proposed to proceed with the establishment of the following specialist services: Eye; ear, nose and throat; X ray; surgery and medicine.

A schedule of fees from surgeon specialists who are prepared to undertake this work is to be prepared.

The specialist services are to be made available to lodge members, only on a written request from their lodge medical officers.

During the last twelve months the number of lodge members handled by the Friendly Societies' Medical and Hospital Council has increased to about 15,000.

Radiological Section.

Inaugurated March 18, 1930.

The Section consists of five members, Dr. B. L. W. Clarke, Dr. Val. McDowall, Dr. Lockhart J. Spence, Dr. A. J. Reye and Dr. J. W. Heaslop. Dr. B. L. W. Clarke was appointed Chairman and Dr. Heaslop Honorary Secretary.

So far the meetings have been held mainly to discuss:

1. The circular regarding fees sent out by the Secretary of the Friendly Societies' Medical and Hospital Council, dated January 31, 1930.

2. To discuss letter dated March 18, 1930, embodying the resolution of the Contract Practice Section Committee of the Branch.

Neither circular nor letter was received favourably by the Section, and it expressed the wish that the matter be referred to the Federal Committee for Australia.

A list of fees for private and lodge patients was asked for and this was sent to the Council on August 20. A reduction of 25% on private fees was suggested for lodge members referred only by their lodge doctors. No further word has been received concerning these fees.

The only other business was that of a request to include the question of X ray examinations for the State Insurance in the scope of the Royal Commission on Hospitals.

*Affiliated Local Associations.**Downs and South Western Medical Association.*

During the past year the Downs and South Western Medical Association (Toowoomba and district) has kept up active work chiefly in regard to inaugurating a scheme of obtaining lecturers from the larger centres. The help of the parent body and Post-Graduate Committee has been very much appreciated in this respect. The scheme has proved an unqualified success.

In June last the President of the Branch, Dr. S. F. McDonald, and the Honorary Secretary, Dr. B. L. W. Clarke, visited Warwick.

There has been a great deal of controversial matter to deal with, but unfortunately, so far as Toowoomba is concerned, the Model Lodge Agreement is held up pending a scale of fees for general and special services being drawn up.

The active membership comprises practically the whole of the medical men within our boundaries.

West Moreton Local Medical Association.

President, Dr. J. A. Cameron; Honorary Secretary, Dr. T. J. Flynn. Membership 20.

Western Medical Association (Charleville and District).
As members are separated by a distance of about 100 miles, no meetings were held during the year. Any business was conducted either by letter or telephone.

Bundaberg Medical Association.
Honorary Secretary, Dr. Egmont Schmidt.

Maryborough Medical Association.
Honorary Secretary, Dr. W. Gillbee Brown.

"The Medical Journal of Australia."
In March last the death occurred of Dr. H. W. Armit, who had held the position of Editor of THE MEDICAL JOURNAL OF AUSTRALIA since 1914. Dr. Mervyn Archdall,

QUEENSLAND BRANCH OF THE BRITISH MEDICAL ASSOCIATION (INCORPORATED).
Statement of Receipts and Payments (General Fund) for Twelve Months ended November 15, 1930.

RECEIPTS.		PAYMENTS.	
£	s. d.	£	s. d.
November 16, 1929.		November 15, 1930.	
To Cash at English, Scottish and Australian Bank, Limited, Brisbane	636 6 2	By British Medical Association, London—	
„ Cash in hand	3 14 2	Remittances on Account of Subscriptions, 1929 and 1930	570 11 3
November 15, 1930.		„ Australasian Medical Publishing Company, Limited—	
To Subscriptions—		Payments for THE MEDICAL JOURNAL OF AUSTRALIA, 1929 and 1930	559 0 0
For remittance to British Medical Association, London	571 16 9	„ Library Expenditure—	
For remittance to THE MEDICAL JOURNAL OF AUSTRALIA, Sydney	560 5 0	Books, Journals and Book-binding	54 1 11
Queensland Branch Subscriptions	258 9 3	„ Branch Expenses—	
Organization Fund, Queensland Branch	731 0 0	Office Salaries and Honorarium	401 6 0
	2,121 11 0	Printing and Stationery ..	49 2 9
„ Subscriptions to Annual Dinner Account	59 17 0	Electric Light	17 8 2
„ Sundry Receipts	15 18 7	Rent	52 0 0
„ Harvey Fund Subscriptions ..	10 10 0	Cleaning	53 10 11
		Telephone	22 1 4
		Bank Charges .. £8 16 7	
		Less Exchanges refunded .. 5 15 9	
			3 0 10
		Exchange on Remittances to London	22 14 11
		Stamps and Telegrams ..	49 0 2
		Audit Fees to November 15, 1929	15 15 0
		Expenses Federal Committee (including Delegate's Expenses)	64 5 0
		Insurance: Fire and Unemployment	3 17 10
		Legal Costs <i>re</i> Amendment of Articles <i>et cetera</i> ..	37 16 0
		Renewals and Repairs Office Furnishings	9 0 2
		Balopticon Operator	3 0 0
		Harvey and Kanavel Film Expenses	9 9 6
		Council and General Meeting Expenses, Newspapers and Sundries	28 16 7
			842 5 2
		„ Expenses in connexion with Lodge Agreement (Contract Forms)	5 5 2
		„ Annual Dinner Expenditure ..	63 19 3
		„ Purchase of 100 Shares in Queensland Medical Land Investment Company, Limited	50 0 0
		„ Remittance of Harvey Fund Subscriptions to British Medical Association, London	10 10 0
		„ Cash at English, Scottish and Australian Bank, Limited, Brisbane	682 16 2
		„ Cash in hand	9 8 0
			£2,847 16 11
			£2,847 16 11

QUEENSLAND BRANCH OF THE BRITISH MEDICAL ASSOCIATION (INCORPORATED).

Building Fund Statement of Receipts and Payments for Twelve Months ended November 15, 1930.

RECEIPTS.			PAYMENTS.		
	£	s. d.		£	s. d.
November 15, 1930.			November 16, 1929.		
To Rents from "Bayview," Wickham Terrace	442	0 0	By English, Scottish and Australian Bank,		
" Refund of Rates by Tenant, "Bayview" ..	59	5 0	Limited, Brisbane—Debit Balance ..	1,329	17 7
" Queensland Medical Land Investment Company, Limited—Dividend 12 months ended November 25, 1929 ..	138	15 0	November 15, 1930.		
" Australasian Medical Publishing Company, Limited—Interest on Debentures to June 30, 1928 ..	4	4 9	By Rates, Land Tax, Insurance and Repairs, "Bayview" ..	168	2 10
" English, Scottish and Australian Bank, Limited, Brisbane—Debit Balance ..	1,251	12 10	" Interest ..	381	12 2
			" Sundry Expenses ..	16	5 0
	£1,895	17 7		£1,895	17 7

who was Assistant Editor, has been appointed Editor. Early in November Dr. Archdall paid a visit to Brisbane and addressed members of the Branch on the subject of the function and scope of the journal.

Joseph Bancroft Memorial Lecture.

The Joseph Bancroft Memorial Lecture was delivered by Mr. Gordon Craig, of Sydney, at the Geology Theatre of the University of Queensland on Friday, June 6, 1930. The subject of the lecture was "Progress in Prostatic Surgery" (with film demonstration). At the conclusion of the lecture the President presented the Bancroft Memorial Medal to the lecturer.

College of Surgeons of Australasia.

An invitation was extended to the members of the Branch by the Committee of the College of Surgeons of Australasia, Queensland, to attend a meeting which was held at the Geology Theatre of the Queensland University on September 26, 1930, when a lecture was delivered by Mr. H. R. G. Poate, of Sydney, entitled "Aspects of Chest Surgery, with Special Reference to Diagnosis and Treatment."

Queensland Cancer Trust.

In September Dr. Val. McDowall, who was one of the representatives of the Branch on the Queensland Cancer Trust, tendered his resignation as a member of the Trust. It was decided to leave it to the incoming Council to appoint a representative in his stead.

Dr. B. L. W. Clarke is the other representative of the Branch on the Trust. With the permission of the Council Dr. Clarke visited Rockhampton and Townsville during the year, under the auspices of the Trust, to ascertain the prospects of organizing centres for the treatment of cancer in both these towns.

Fees for Medical Witnesses.

Although the Attorney-General has been interviewed on this matter and several attempts have been made to have the unsatisfactory position adjusted, finality has not yet been reached. The question, however, is to be dealt with in the Coroners Bill, which is to come before Parliament shortly.

Frontier Medical Service: Australian Inland Mission.

During the year discussions were held with representatives of the Australian Inland Mission with regard to the establishment of the Frontier Medical Service. The attitude and objects of both parties were defined, and it was possible to assure the Australian Inland Mission of the hearty cooperation of the Branch in their work.

Special Medical Funds.

Members of the Branch have contributed to the following special medical funds: William Harvey Memorial Fund, Sir Patrick Manson Memorial Fund and the Armit Fund.

British Medical Association Centenary, 1932.

The Centenary of the British Medical Association will be held in London in 1932, and it is hoped that representatives will be present from this Branch. Any members who intend visiting England about this time should get into touch with the Branch Council. Information will, of course, be published in the medical journals from time to time.

Motor Car Badges for Members.

Badges for motor cars have been issued to over one hundred members during the year. Applications for badges have been received from a number of members in country centres.

Road Accidents: Responsibility for Fees.

A statement was made to the Honorary Secretary by the Commissioner of Police to the effect that if it could be shown that a medical man was called by a policeman to the scene of an accident, the Department is liable for the fee. If any other person calls the medical man the Police Department is not liable for the fee. The Commissioner stated that he was at all times willing to furnish members of the Association with full particulars of names and addresses of the persons concerned in the road accidents, in order to locate the patients.

Grey Street Bridge.

In March last, at the invitation of the contractors, Messrs. M. H. Hornibrook, Limited, members of the Branch paid an interesting visit of inspection of an airlock of the Grey Street Bridge, which is in course of construction over the Brisbane River.

Social.

On Thursday, June 5, the annual dinner of the Branch was held at Rowe's Banquet Hall, the attendance being sixty-five. The guests of honour were His Excellency Sir John Goodwin, Mr. Gordon Craig, Sydney, Mr. Alan Newton, Dr. S. V. Sewell and Professor R. Marshall Allan, of Melbourne. An enjoyable programme was contributed to by Messrs. R. L. Wishart and J. Land.

Prior to the Bancroft Memorial Lecture, which was held on June 6, the President entertained the members of the Council and the visitors from the other States at dinner.

In connexion with the opening of the post-graduate course, a dance and bridge evening was held at the Carlton Cabaret on Monday, June 2. The arrangements were in the hands of Dr. V. N. B. Willis and Dr. M. Graham Sutton. There were one hundred and eighty-two members and their friends present, and a most enjoyable evening was spent.

(Signed) S. F. McDONALD,
President.

B. L. W. CLARKE,
Honorary Secretary.

ELECTION OF OFFICE-BEARERS.

The President announced the result of the election of office-bearers and members of the Council.

President: Dr. F. A. Hope Michôd.

President Elect: Dr. E. S. Meyers.

Past President: Dr. S. F. McDonald.

Honorary Secretary: Dr. B. L. W. Clarke.

Representatives on the Federal Committee: Dr. D. Gifford Croll, Dr. E. S. Meyers.

Members of the Council: Dr. Hedley Brown, Dr. Gavin Cameron, Dr. D. Gifford Croll, Dr. C. M. Lilley, Dr. F. W. R. Lukin, Dr. N. W. Markwell, Dr. Alex Murphy, Dr. M. S. Patterson, Dr. W. N. Robertson, Dr. Graham Sutton, Dr. Neville G. Sutton, Dr. D. E. Trumpy, Dr. C. E. Tucker, Dr. Kenneth Wilson. *Proxime accessit:* Dr. Ellis Murphy.

On the motion of Dr. F. A. H. Michôd, seconded by Dr. B. L. W. Clarke, Mr. Roy G. Groom was appointed auditor.

PRESIDENT'S ADDRESS.

Before vacating the chair Dr. S. F. McDonald read his address (see page 841).

INDUCTION OF PRESIDENT.

Dr. S. F. McDonald then inducted the new President, Dr. F. A. H. Michôd, to the chair.

Dr. F. A. H. Michôd thanked the members for electing him to the chair and said that he considered it a compliment paid to country members. He knew that it would be a hard position to hold and that it would be difficult to follow Dr. McDonald. He would, however, be helped by the President Elect and by a capable Council.

Dr. Michôd proposed a vote of thanks to Dr. S. F. McDonald. This was carried by acclamation.

Dr. Michôd referred to the work done by Dr. Meyers in connexion with the Royal Commission on Hospitals. A vote of thanks was accorded to Dr. Meyers and to Mrs. Spooner.

MEDICO-POLITICAL.

The Victorian Branch of the British Medical Association has requested that the following statement be published.

Suggestions for a Uniform Procedure in Holiday Consultations.

The Council has approved of the following suggestions drawn up by the Ethical Subcommittee, with the object of bringing about a uniform practice in holiday consultations.

It is to be noted that these suggestions have not been adopted as rules, but, if generally accepted, would do away with the position of uncertainty at present prevailing as to the proper procedure in such cases:

1. It is a recognized rule that no practitioner is compelled to attend an emergency call, but, having seen the case, or advised treatment, responsibility for the case is accepted.

2. Where no resident practitioner is available, the visitor is entitled to attend patients if requested and should charge such fees as would obtain if he were treating the case at home.

3. Where there is a reputable medical practitioner established in, or within a reasonable distance of, the holiday resort (say ten miles), the visitor should only consent to see a patient as acting for his colleague. If, after this, his opinion is further desired, he should only act as consultant, and charge consultant fees.

4. If a reputable medical practitioner is established outside a ten-mile radius, but nevertheless makes regular visits at short intervals to a holiday resort, he may be regarded as being a resident practitioner.

5. Some modification of the above suggestion may be permissible where the visiting practitioner and the patient already stand in the relation of doctor and patient at home. If, however, attendance is given under such conditions, the

practitioner should charge such fees as he would if attending the case at home.

If the local practitioner is already in attendance the visitor should only act as consultant.

6. Where the visitor is compelled to undertake a case which appears likely to require prolonged attention, arrangements should be made for the transfer of the patient to the usual medical attendant, if there be one, at the earliest opportunity.

7. Where a practitioner is summoned from home to attend a patient at a holiday resort, full mileage rates should be added to the fee.

8. Gratuitous advice at holiday resorts is to be deprecated, except under such circumstances as would obtain at home.

NOMINATIONS AND ELECTIONS.

The undermentioned have been nominated for election as members of the New South Wales Branch of the British Medical Association:

Read, John Richard Major, M.B., Ch.B., 1929 (Edinburgh), 8, Porchester Road, Bellevue Hill.

Gaffney, Thomas Joseph, M.B., 1930 (Univ. Sydney), Bonalbo.

Anderson, Douglas Joseph, M.B., B.S., 1930 (Univ. Sydney), "Afton," Greenwich Point.

The undermentioned have been nominated for election as members of the Queensland Branch of the British Medical Association:

Digiaco, Anthony, M.D. (Genoa), 123, Abbott Street, Cairns.

Vattuone, Angelo B., M.D., 1928 (Genoa), 88, Abbott Street, Cairns.

The undermentioned have been elected members of the Victorian Branch of the British Medical Association.

Raphael, Cecil Neville, M.B., B.S., B.Sc., 1930 (Univ. Melbourne), 155, Victoria Parade, Fitzroy, N.6.

Short, Oswald Victor, L.R.C.P. et S. (Edinburgh), L.R.F.P.S. (Glasgow), 1930, 43, Cochrane Street, North Brighton, S.5.

Public Health.

DANGEROUS DRUGS REGULATIONS.

The Council of the Victorian Branch of the British Medical Association has forwarded for publication the following letter from the Registrar of the Pharmacy Board of Victoria.

Pharmacy Board of Victoria,
360, Swanston Street,
Melbourne, C.1.

13th November, 1930.

The Secretary,
British Medical Association,
Albert Street,
East Melbourne.

Dear Sir,

I have been requested by the Board to forward you a copy of the Dangerous Drugs Regulations, 1930. Several of the regulations are of direct importance to medical men, particularly Sections 12, 14, 15, 16 and 17.

As probably a number of practitioners are not aware of the desirability of strictly conforming to the regulations, the Board would be glad if, when you are next circularizing your members, you would include a brief

note drawing special attention to Regulations 15 (a), (d), (f), (g), (h) and (i), 16 and 17.

If the text of the regulations above referred to could be communicated to your members and emphasis laid on the necessity of a strict observance of the legal requirements, such action on the part of your Association would be greatly appreciated by the Board.

Yours faithfully,

C. L. BUTCHERS,
Registrar.

Regulations 12, 14, 15, 16 and 17 are as follows:

12. In the event of any person authorized by any licence granted by the Board under Section 40 of the Act being convicted of any offence against the Act or these Regulations, or of an offence under any enactment relating to Customs as applied to the importation of dangerous drugs, the Chief Secretary may, on the recommendation of the Board by notice published in the *Government Gazette*, cancel such licence.

14. Except in pursuance of a prescription given by a duly qualified medical practitioner, registered dentist, or registered veterinary surgeon, in accordance with the provisions of these Regulations, no person shall supply or procure or offer to supply or procure or cause to be supplied or procured any dangerous drug to or for any person who is not licensed or otherwise authorized to be in possession of dangerous drugs:

Provided that the administration of any dangerous drugs by or under the direct personal supervision, and in the presence of a duly qualified medical practitioner or by or under the direct personal supervision and in the presence of a registered dentist in the course of dental treatment, or by or under the direct personal supervision and in the presence of a registered veterinary surgeon in the treatment of any animal, or by a registered nurse acting under specific instructions of a legally qualified medical practitioner shall not be deemed to be the supplying of a dangerous drug within the meaning of these Regulations:

Provided also that a registered pharmaceutical chemist or a person holding a licence as a general dealer in poisons under the *Poisons Act 1928* may supply tincture of opium for veterinary purposes without a prescription, provided that the drug is required for bona fide veterinary purposes only, and that an entry of the sale is made forthwith in the poisons book and in the register required to be kept under these Regulations.

15. Except in the case of emergency, as hereinafter provided, a prescription for the supply of a dangerous drug shall comply with the following conditions:

(a) The prescription shall be in writing, shall be dated and signed with the usual signature of the person authorized to give it, and shall specify his own address and the name and address of the person for whom the prescription is given.

(b) A prescription for a dangerous drug when given by a registered dentist for the purpose of dental treatment shall be marked "for local dental treatment only."

(c) A prescription for a dangerous drug when given by a registered veterinary surgeon shall be for the purposes of treatment of animals and shall be marked "for animal treatment only."

(d) No prescription shall be given for the supply of a dangerous drug otherwise than in accordance with the foregoing conditions.

(e) A medical practitioner or veterinary surgeon who dispenses any medicines to which these Regulations apply shall enter particulars thereof in the register hereinafter specified.

(f) Every medical practitioner who writes a prescription containing a dangerous drug shall write on such prescription the maximum number of times such prescription shall be dispensed.

(g) Where the prescription contains an unusual, or what may be regarded as a dangerous dose, the prescriber shall indicate that such dose is intended by underlining that part of the prescription and by inserting his initials in the margin.

(h) The use of a rubber stamp or other such contrivance in lieu of the written signature on a prescription for dangerous drugs is hereby prohibited.

(i) The prescription shall not be written in a secret code or cypher.

16. A medical practitioner, registered dentist, or registered veterinary surgeon shall not—

(a) knowingly give a prescription for a dangerous drug merely for the purpose of addiction, or

(b) knowingly supply or administer a dangerous drug merely for the purposes of addiction.

17. In an emergency case where a prescription is issued orally to any pharmaceutical chemist, such prescription shall be forthwith reduced to writing and given or despatched without delay to such chemist by the person issuing it.

Correspondence.

TYPHOID FEVER AND CARRIERS.

SIR: The interesting series of typhoid cases infected by a carrier, reported by Dr. Penfold in the journal of November 29, illustrates very forcibly the danger that an unsuspected carrier may be. This danger is accentuated in rural areas and scattered townships with their frequently primitive methods of sanitation. In the journal of March 15, 1924, page 274, I gave details of a small milk-borne outbreak in a country town which had its origin from an elderly carrier who gave a history of having had no typhoid fever for the previous seventeen years. Last year I became aware of several series of cases, one certainly and others probably originated by carriers, and notes of them may be of interest, especially in view of the extreme youth of one.

SERIES I.—A.B., a small boy, aged three years, living in a small scattered township, was admitted to Hamilton Hospital on March 16, 1929, and was reported as a case of typhoid fever. His illness dated from the ninth. No history of typhoid was elicited from his parents, but he had recently returned from a several weeks' visit to his paternal grandmother, who had had typhoid forty years before. He gave a positive Widal. He was discharged from hospital and returned home on May 3, 1929, and the subsequent sequence of events was as follows:

June 14, 1929, C.D., *atatis* eleven, a playmate of an older brother of A.B., admitted to hospital with typhoid fever (Widal positive).

June 18, 1929, B.B., brother of A.B., *atatis* seven, admitted to hospital with typhoid fever (Widal positive).

June 21, 1929, C.B., another brother, *atatis* five, admitted to hospital with typhoid fever (Widal positive).

June 24, 1929, A.B.'s father and infant brother admitted to hospital for observation. Not typhoid.

Specimens of faeces from all these patients and from A.B., who was recalled to hospital to secure a specimen, were forwarded to the University Laboratory; only that from A.B. showed the presence of *Bacillus typhosus*. In the meantime the Group Health Inspector, Mr. Salthouse, visited the township on the occurrence of the first case and caused the pan contents at the school attended by the children and at the homes of the patients to be burned. The closets were all well cleansed and disinfected and the Shire Council provided a liberal supply of phenyle for the future disinfection of closet pans. The township being small, there is no pan service, householders burying on their own grounds. The mothers of the patients (Mrs. B. and Mrs. D.), as well as several of the neighbours, were all inoculated with typhoid vaccine.

The Medical Officer of Health lives in a neighbouring township and the Group Health Inspector in a town some twenty-seven miles away, but as far as possible the family was kept under observation. However, towards the end of August, 1929, Mrs. B., taking A.B. with her, went to stay with her mother, Mrs. P., to help look after her, as the latter was ill. Her sister, Mrs. R., also stayed with Mrs. P. On September 17, 1929, Mrs. P. died and the two

daughters returned to their respective homes, Mrs. R. not feeling well. Very shortly after her return home she also was admitted to Hamilton Hospital and was reported as suffering from typhoid fever on October 21, 1929 (Widal positive). Specimens of faeces from A.B. sent for examination again showed the presence of *Bacillus typhosus*.

At this time I observed a reference in Parkes and Kenwood, 1929 edition, to the effect that oral immunization with typhoid vaccine, adopted in South Africa, was also efficacious in clearing up recent carriers. Details of this were given by Cluver in *The Lancet* and by Boyd, Medical Officer of Health, Pretoria, in a letter to *The British Medical Journal* of January 28, 1928. I accordingly wrote to Dr. Cluver, who passed my letter on to Dr. Spencer Lister, of the South African Institute for Medical Research, who kindly forwarded me literature and a dozen outfits, each containing three ox bile tablets and three typhoid vaccine tablets. These were supplied gratis.

In the meantime further specimens of faeces from A.B. were secured by Mr. Salthouse and were submitted to the University Laboratory in November, 1929, and in January and March of this year, but in none of them was the presence of *Bacillus typhosus* detected, so we concluded that A.B. had ceased to be a carrier. The material was accordingly forwarded to the University Laboratory, as the opportunity of using it in this case no longer existed. While A.B. was under suspicion, his faeces were daily incinerated—after being deposited on a piece of stout paper they were burned in a kerosene tin on a pyre of chips gathered from the wood heap by the small carrier himself.

SERIES II.—About the same time Series II occurred in a town about sixty miles from A.B. No connexion between the two groups of cases could be traced. This was a milk-borne outbreak; the first case appears to have been a baby.

A.L., *atatis* sixteen, attending high school in a neighbouring town, but returning home at week-end, fell ill on April 9, 1929; admitted to hospital, he was first looked on as a pneumonia, then as a possible cerebro-spinal meningitis, and finally his condition was diagnosed as typhoid (Widal positive).

April 26, 1929, R.L., brother of A.L., became ill and was admitted to hospital on May 2, 1929, with typhoid.

April 25, 1929, J.M., brother-in-law of A.L. and R.L., had meals at L's house.

April 6, 1929, A.N., *atatis* nine, became ill; looked on as influenza at first.

The L., M. and N. households derived their milk supply from the father of the baby above referred to. He owned two cows and supplied a few neighbours. His wife had had typhoid thirty years previously; so had Mrs. L. (twenty years previously). These were the only two known contacts who gave any typhoid history. The baby was ill from March 22, 1929, looked on as entero-colitis. No *Bacillus typhosus* was found in the faeces of either of the contacts with typhoid histories, or from the baby. There was nothing to show how the baby became infected, nothing but a vague history of a visitor to the household in January, who brought in a sick child to see the doctor. This child was looked on as pneumonia; it could not be traced.

SERIES III occurred on a farm in yet another part of the district. There were five cases, a mother, two sons and two daughters. The first case was regarded by the father as influenza, but the doctor in attendance early suspected typhoid and sent blood for examination. The dates of onset were February 12, 13, 19, 20, 20, 1929. Later on it transpired that two cases which had developed in another State at this time were associated with these. Sanitation was faulty, the contents of the pan closets (it was on a farm) being deposited in an open pit not far from the house. Late in January a visitor had stayed at the house, for a week. He gave no history of typhoid, but stated that he had suffered from recurrent attacks of diarrhoea for the past seven years. Two specimens of both faeces and urine were sent for examination, but *Bacillus typhosus* was found in neither. No connexion between this group and either of the other two groups could ever be traced. All the contacts in this outbreak were immunized by Dr. Tunbridge, the Medical Officer of Health.

In addition to these three groups, there were in 1929, as in most years, isolated cases. These must have become infected, either directly or indirectly, by either preexisting, mild, undiagnosed cases or from unsuspected carriers. Often no clue to the latter exists. Even when one suspects the carrier condition, it is not easy to prove. C.X. was admitted to hospital on February 2, 1929, reported as typhoid on February 11, 1929 (Widal positive). Inquiry revealed that both his parents had had typhoid (Widal positive) three years previously, the father from April 28, 1926, to June 1, 1926, the mother from March 31, 1926, to May 22, 1926. I secured specimens of faeces from both parents on March 12, 1929, and March 25, 1929. All were negative.

It is extremely probable that there is still a considerable number of carriers in the State. Bacteriological examination of sewage in Belfast and Edinburgh, as recorded by Wilson (*The British Medical Journal*, June 23, 1928, page 1061) and Gray (*The British Medical Journal*, January 26, 1929, page 143) demonstrated the presence of considerable numbers of carriers in those cities. As until comparatively recently the typhoid incidence of this State was much higher than that of the United Kingdom, it is not unreasonable to suppose that in this country also there must be many carriers, actual and potential. Every case of typhoid diagnosed should provoke a search for an antecedent case or a possible carrier. Should the carrier condition be proved, the medical officer of health has quite extensive powers and duties in the matter under the Infectious Diseases Regulations. In any case, as suggested by Dr. Penfold, immunization of contacts should be carried out.

Yours, etc.,

GEORGE COLE,
District Health Officer,
Western District, Victoria.

December 2, 1930.

A PSYCHOLOGICAL CONUNDRUM.

SIR: Maeterlink has written a charming history of the honey bee, in which he favourably compares its intelligence and industry with that of the human race. In my boyhood the ant was frequently quoted as an object lesson to the young.

The sterile female working bee has a sting, and the ant, particularly its bulldog variety, has an unpleasant bite; both are fearless and aggressive if interfered with. The venomous snakes are anathema to human life, and make one of the earliest entries into the bush girl's chamber of horrors. They are divided into two distinct classes, the viperiform and the colubrine. All the viperiform are venomous, but the colubrine include many that are innocuous.

The wonderful mechanical arrangement of the skull and lower jaw which permits of the poison being expressed from the poison gland through its poison fang into its victim when the snake strikes, differs a little in these two forms, the nature of the poison also differing slightly.

In the colubrine it is mainly a nerve poison of great deadliness. In the viperine, however, it is a more potent blood poison. From a death-dealing standard of efficiency, both are effectual.

The original cell in an early stage of the snake's evolution, does not appear, however, to have been uniform in its effect upon the developing snake; as in the colubrine, some are venomous and some not. There appears, therefore, to be evidence of an undefined outside influence acting upon the cerebral cell of the developing snake, in the one case producing the elaborate mechanical apparatus of the poison variety and in the other the simple skull and dentition of its non-venomous form.

Both types of snake have a very low grade of intelligence and having now attained their full development, it is probable that in regard to future evolution they are at a dead end.

It is a long way to travel in evolution from the snake to the modern human unit.

At a very early period in the history of man he has gradually been weaned of many of his primitive animal

characteristics. His true evolution appears to have commenced when he developed the power of recording his intellectual and emotional achievements. Indeed, the subconscious mind of the human unit is practically to be found in the record of its intellectual and emotional achievements.

The continued progress of human life depends upon the increasing emotional and intellectual value of the subconscious mind and an early and increasing activity in the nerve cells. Thus we detect in the work of a genius, particularly a musical genius, an active cerebration in infancy. Is this intellectual and emotional progress the result also of an undefined directing outside influence? This is a psychological conundrum which the thoughtful human unit must determine for itself.

Yours, etc.,

GEORGE HENRY TAYLOR.

1, Kirk Oswald Avenue,
Mosman, New South Wales.
December 3, 1930.

Books Received.

MINOR MONOGRAPH SERIES: DISEASES OF THE THYROID GLAND, by N. B. Foster, with a Section on Malignant Growths by E. H. Pool; 1930. London: Baillière, Tindall and Cox. Crown 8vo., pp. 180, with illustrations. Price: 6s. net.

CLINICAL CHEMISTRY IN PRACTICAL MEDICINE, by C. P. Stewart, M.Sc., Ph.D., and D. M. Dunlop, B.A., M.D., M.R.C.P.; 1930. Edinburgh: E. and S. Livingstone. Crown 8vo., pp. 256. Price: 7s. 6d. net.

DISEASES OF THE SKIN, A TEXT-BOOK FOR PRACTITIONERS AND STUDENTS, by George Clinton Andrews, A.B., M.D.; 1930. Philadelphia: W. B. Saunders; Melbourne: James Little. Crown 4to., pp. 1101, with 988 illustrations. Price: 66s. net.

DIETETICS IN WARM CLIMATES, INCLUDING FOOD-STUFFS, THEIR ANALYSES AND ROLE IN DISEASE, by J. Nell Leitch, M.D., B.S., F.R.C.S., L.R.C.P., D.T.M. & H., F.R.G.S., F.Z.S., with an introduction by Sir J. A. Byrne, K.C.M.G., K.B.E., C.B.; 1930. London: Harrison and Sons Limited. Royal 8vo., pp. 486. Price: 25s. net.

Medical Appointments.

Dr. S. R. Burston (B.M.A.) has been appointed a Member of the Nurses' Board of South Australia, under the provisions of the *Nurses' Registration Act*, 1920.

Dr. A. F. Hobbs (B.M.A.) has been appointed Honorary Assistant Pathologist at the Adelaide Hospital.

Dr. M. A. Trudinger (B.M.A.) has been appointed Honorary Medical Officer to the Port Pirie Hospital, South Australia.

Dr. R. McM. Glynn (B.M.A.) has been appointed Honorary Assistant Aural Surgeon at the Adelaide Hospital.

Dr. K. McEwin (B.M.A.) has been appointed a Member of the Nurses' Board of South Australia under the provisions of the *Nurses' Registration Act*, 1920.

Medical Appointments Vacant, etc.

For announcements of medical appointments vacant, assistants, locum tenentes sought, etc., see "Advertiser," page xvi.

BALONNE HOSPITALS BOARD, QUEENSLAND: Medical Officer.
CHILDREN'S HOSPITAL, INCORPORATED, PERTH, WESTERN AUSTRALIA: Junior Resident Medical Officers.

Medical Appointments: Important Notice.

MEDICAL practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, Tavistock Square, London, W.C.1.

BRANCH.	APPOINTMENTS.
NEW SOUTH WALES: Honorary Secretary, 135, Macquarie Street, Sydney.	Australian Natives' Association. Ashfield and District United Friendly Societies' Dispensary. Balmain United Friendly Societies' Dispensary. Friendly Society Lodges at Casino. Leichhardt and Petersham United Friendly Societies' Dispensary. Manchester Unity Medical and Dispensing Institute, Oxford Street, Sydney. North Sydney Friendly Societies' Dispensary Limited. People's Prudential Assurance Company, Limited. Phoenix Mutual Provident Society.
VICTORIAN: Honorary Secretary, Medical Society Hall, East Melbourne.	All Institutes or Medical Dispensaries. Australian Prudential Association Proprietary, Limited. Mutual National Provident Club. National Provident Association. Hospital or other appointments outside Victoria.
QUEENSLAND: Honorary Secretary, B.M.A. Building, Adelaide Street, Brisbane.	Members desiring to accept appointment in ANY COUNTRY HOSPITAL, are advised to submit a copy of their agreement to the Council before signing, in their own interests. Brisbane Associated Friendly Societies' Medical Institute. Mount Isa Hospital. Mount Isa Mines.
SOUTH AUSTRALIAN: Secretary, 207, North Terrace, Adelaide.	All Lodge Appointments in South Australia. All Contract Practice Appointments in South Australia.
WESTERN AUSTRALIAN: Honorary Secretary, 65, Saint George's Terrace, Perth.	All Contract Practice Appointments in Western Australia.
NEW ZEALAND (Wellington Division): Honorary Secretary, Wellington.	Friendly Society Lodges, Wellington, New Zealand.

Editorial Notices.

MANUSCRIPTS forwarded to the office of this journal cannot under any circumstances be returned. Original articles forwarded for publication are understood to be offered to THE MEDICAL JOURNAL OF AUSTRALIA alone, unless the contrary be stated.

All communications should be addressed to "The Editor," THE MEDICAL JOURNAL OF AUSTRALIA, The Printing House, Seamer Street, Glebe, New South Wales. (Telephones: MW 2651-2.)

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JAN 29 1931

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VOL. II.—17TH YEAR.

SYDNEY, SATURDAY, DECEMBER 27, 1930.

No. 26.

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